North Carolina Aging Services Plan

2007-2011

putting the pieces together

Division of Aging and Adult Services
NC Department of Health and Human Services
March 2007

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The 2007-2011 North Carolina Aging Services Plan

putting the pieces together

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Michael F. Easley, Governor

Carmen Hooker Odom, Secretary

March 1, 2007

Dear North Carolina Aging Colleague:

The North Carolina Department of Health and Human Services is pleased to present the *2007–2011 State Aging Services Plan*, as required by NCGS 143B-181.1A and the federal Older Americans Act. This *Plan* updates the *2003–2007 Plan*, which extensively reviewed trends and issues relevant to today's seniors and aging boomers. Most importantly, the *2007–2011 Plan* sets forth an agenda to better help North Carolina respond to the aging of our population.

We are proud of North Carolina's accomplishments benefiting seniors and their families since 2003. During this four-year period since the previous *Plan*, a number of State agencies have been involved in providing services and implementing programs aimed at maintaining and improving the quality of life of seniors and their families and preparing boomers for their later years.

We developed the *2007–2011 Plan* within the framework of the livable and senior-friendly communities initiative, which was introduced in the *2003–2007 Plan*. The forty objectives for the coming four years are presented in the eight components of this initiative: physical and accessible environment, healthy aging, economic security, technology, safety and security, social and cultural opportunity, access and choice in services and supports, and public accountability and responsiveness. This new *Plan* is available on the Division of Aging and Adult Services' (DAAS) website (www.ncdhhs.gov/aging/), with links to additional information.

While the authorizing State and federal legislation require DAAS to develop this *Plan*, the division sought wide input from other State agencies as well as North Carolina's 17 Area Agencies on Aging and invited participation from consumers, service providers, and educators. I wish to thank the many individuals and groups who contributed information and ideas. With the aging of our population, we must plan not only for what government can and should do, but also acknowledge and support the efforts of individuals, families, and communities.

Our collective goals are to draw upon the talents and resources of seniors, while enhancing services for those who are most vulnerable; value diversity, while addressing disparity; be responsible stewards of resources, including support of family caregiving; and help the boomers prepare for their future. I hope you will join us in planning for and supporting the development of livable and senior-friendly communities to the benefit of North Carolinians of all ages.

Carmen Hooker Odom

Executive Summary

Every four years, the NC Division of Aging and Adult Services uses its *State Aging Services Plan* to report on the status of seniors and offer objectives and recommended actions to the General Assembly and the US Administration on Aging. With the *2007–2011 State Aging Services Plan*, we have examined many of the needs and wishes of current and future older adults and discussed ways to make our communities more responsive and supportive, not only for our aging population but also for North Carolinians generally. Like a steadily rising tide, boomers are entering the ages where they are beginning to need and qualify for aging services and programs. Many of them are learning about and turning to the services system as they care for parents and older relatives in their 70s, 80s, and 90s. Both seniors today and those who follow are also making substantial contributions to the vitality of our State and communities.

This *Plan* represents the collaborative work of older adults and advocates, regional and community planners, and service providers, both public and private. Much of their input has come through the work of our State's 17 Area Agencies on Aging as they have developed Area Plans and supported local planning. In the *State Plan*, we identify achievements since the last *Plan* was introduced in 2003, which have provided the foundation for many of the objectives we set forth here. Local emerging issues and priorities of the partnering groups and other stakeholders have also guided the selection of objectives. We have sought to be ambitious in what we wish to undertake in the next four years, while being realistic about what we can accomplish.

This *Plan* is set out in four major chapters. The first, on demographics, provides a thumbnail review of the great shift in the age structure of our State that will influence all we do for the next 25 to 30 years. We also examine some of the ways current older adults differ from those to come. The second chapter describes the model that best captures our aspirations for the future—that North Carolina will be acknowledged throughout the country as the State whose livable and senior-friendly communities support the well-being of all our residents. Toward the creation of livable and senior-friendly communities, the third chapter sets out our objectives under eight areas: physical and accessible environment, healthy aging, economic security, technology, safety and security, social and cultural opportunity, access and choice in services and supports, and public accountability and responsiveness. In each area, there is a review of our accomplishments and the introduction of five principal objectives, with a brief rationale, list of potential collaborators, and in several cases, identified strategies currently under way or soon to begin. Chapter four concludes with a call to action.

Because we intend this document to serve as a reference and baseline from which to judge our progress, the appendixes include a listing of the departments and offices at the State level that provide services to older adults and their families; a list of the Area Agencies on Aging; emerging issues as identified in the area plans of the Area Agencies on Aging; a review of the recommendations of North Carolina's State-authorized advocates for older adults; a review of expenditures for public services to older adults in State Fiscal Year 2005–06; and a list of acronyms and references used in the preparation of this document.

Some may view the unprecedented growth of the older population as a risk to the State—certainly a greater number of older people will bring a greater demand for services, even if improvements in health care reduce the proportion of people with age-related disabilities or delay the onset of disease. However, it has been said that "a rising tide lifts all boats." The upwelling of a mature population also brings with it knowledge, experience, civic-mindedness, and other resources that are critical elements of the State's social capital that it can tap to improve the well-being of all.

Livable and Senior–Friendly Communities Objectives At A Glance

The objective statements here have been abbreviated.
The objectives in full are found in Chapter III.

Physical and Accessible Environment

1. A pilot information campaign to increase awareness of public and private transportation options for older adults and their families.

2. State assistance to local Aging Leadership Planning Teams for transportation needs assessment and planning.

3. A web site about driving safety issues and alternative transportation for an aging population.

4. A dedicated revenue source for a Housing Trust Fund for seniors and others with limited resources.

5. Expanded State-funded rental assistance programs to assist seniors and others with limited resources in affording safe, adequate, and accessible housing in their communities.

Healthy Aging

6. Education and publicity about Medicare Part D, NCRx, and related policies and programs.

7. Evidence-based health promotion and chronic disease management programs.

8. Expanded access to dental care for seniors with special needs.

9. Interventions to encourage older adults to name a surrogate decision-maker for health care and express their preferences for care at the end of life; education about advance directives for health and human services providers.

10. Support for regional Geriatric/Adult Mental Health Specialty Teams in addressing long-term care needs of older adults with mental illness.

Economic Security

11. Improved legislative and private support for family caregivers in the workplace.

12. A publicity campaign to highlight issues affecting older workers and emphasize their value to the workforce.

13. Participation in the federal "Own Your Future" personal long-term care planning campaign.

14. A Long-Term Care Partnership Program to reduce future Medicaid costs.

15. Seniors' improved participation in the Food Stamp Program.

Technology

16. A pilot project to increase availability of assistive technology in underserved and rural areas.

17. Education and training on use of assistive/adaptive devices for people who are deaf or hard of hearing or who have vision impairments.

18. A campaign to publicize available funding resources for assistive technology.

19. Implementation of NC care LINK, a web portal for information about community resources.

20. An automated, uniform screening and assessment process for services funded by Medicaid, also piloted with services funded in other ways.

Safety and Security

21. Special medical needs registries in each county along with comprehensive disaster plans for medically fragile individuals, if feasible.

22. Comprehensive dissemination of consumer fraud alerts; implementation of a Victims Assistance Program in at least 50 counties.

23. Support for initiatives that address shortages and growing demand for direct-care workers in long-term care settings.

24. Implementation of Adult Protective Services Clearinghouse Model in 20 county departments of social services.

25. Increased safety for people with Alzheimer's disease and other dementias, especially for those who wander.

Social and Cultural Opportunity

26. Model libraries that promote opportunities for life enrichment and learning in a maturing society.

27. Trained Benefits Navigator volunteers in all 100 counties to counsel older adults and people with disabilities about available public benefits.

28. Outreach to minority and non-English-speaking seniors.

29. Increased participation in SilverArts.

30. More senior centers certified through the State's voluntary program.

Access and Choice in Services and Supports

31. Standard caregiver assessment as part of care planning, and expansion of Project C.A.R.E. and other caregiver supports.

32. Six well-established Aging and Disability Resource Centers, with appropriate use of senior centers.

33. Support for self-directed/consumer-directed models of service delivery across DHHS agencies.

34. State-County Special Assistance In-Home (SA/IH) Program for Adults in all 100 counties.

35. Strengthened adult day services as part of the continuum of long-term care.

Public Accountability and Responsiveness

36. Pilot tools and training materials for the Quality Improvement Consultation Initiative in Adult Care Homes.

37. A comprehensive planning model for livable and senior-friendly communities, and a web-based clearinghouse to support local initiatives.

38. Identification and training of future senior leaders.

39. Support for increased local capacity for performance-based measurement.

40. An efficient data tracking system for planning, monitoring, development, and evaluation of HCCBG service delivery.

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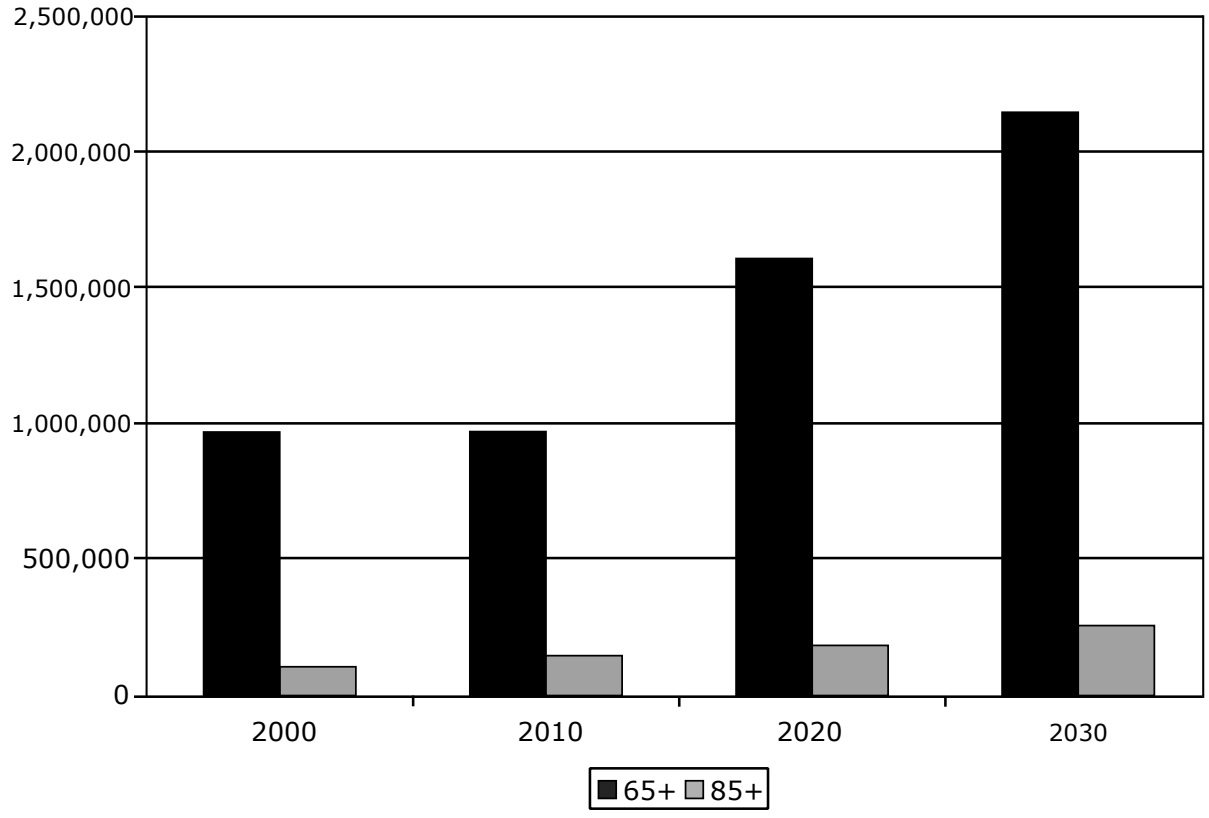
I. Demographics

Growth and stability in the numbers of older adults

North Carolina, with the rest of the US, faces two distinct challenges in the area of aging. The first is to provide support and opportunities to the remaining members of "the greatest generation"—those who were young men and women during World War II, and who are now in their 80s and older, as well as today's "young old" as they age and grow more vulnerable. The second is to prepare for the transition of the "baby boomers" into retirement ages, the first of whom turned 60 in 2006. The boomers will transform the age structure of the State and bring a new generation of older adults with some of the same historic challenges, but also new attitudes, new challenges, and new resources.

Some people have spoken of the aging of the boomers as an "age wave," and some have spoken of it as a "tsunami." To use a similar analogy, North Carolina's aging services system is now entering the calm before the storm. As Figure 1 shows, the projected growth of the population 65 and older between 2000 and 2010 is very low. In fact, the projected number of North Carolinians 65 and older for 2006 (1,050,849) is larger than the projected figure for 2010 (971,058). Whether or not the number of older adults in the State actually takes a small, temporary dip, the years covered by this *Plan* will be an unprecedented time of slow or no growth in the size of the older population as a whole.

Figure 1. Projected Growth of Older North Carolinians, 2000 to 2030

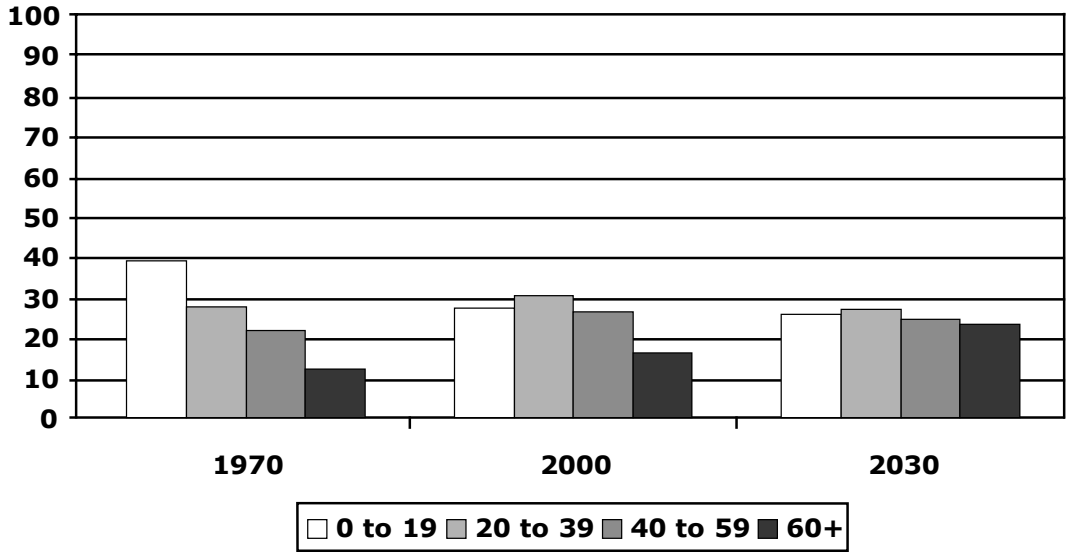


Why is this? Because between the great stock market crash of 1929 and the end of World War II in 1945, the country experienced unusually low birth rates—at first because people could not afford to marry or to have large families, and then because a high proportion of the potential fathers were away at war. The relatively small group of people born during that period will be 62 to 78 years old in 2007, while the older population will be made up of the much larger cohorts born in the second and third decades of the twentieth century. Because of this trend, the overall population 65 and older remains stable from 2000 to 2010, but the population 85 and older will grow almost 39 percent, from 105,461 (1.1 percent of the population) to 146,529 (1.6 percent of the population).

By 2030, 75 of our counties are projected to have more people 60 and older than 17 and younger.

In the following decade, from 2010 to 2020, it is the younger half of the older adult population that will grow more dramatically as that small cohort ages and more and more members of the baby boom cohort retire. By 2030, the youngest members of the boomer cohort will turn 66. As Figure 2 demonstrates, in that year the State will have a nearly flat age structure with about a quarter of the population under 20 and about a quarter over 60. This is in marked contrast to the "stair step" pattern in 1970 and most of our State's and nation's history. Unless some health or social change creates a dramatic difference in deaths, births, or migration, this "flat" age structure will continue indefinitely into the future.

Figure 2. NC Population by Age Group, 1970 to 2030



How does NC compare to the US as a whole?

As Table 1 shows, North Carolina is similar to the US on a variety of demographic, health, and economic indicators. North Carolinians of all ages are more likely to live in rural areas, but not more likely to live on farms. The composition of the NC population is slightly younger than the US (proportionately fewer people over 65 and over 85), has a slightly higher percentage of women in the older ages, and has a much larger percentage of older adults who claim African American heritage. By contrast, the percentage of older adults who report Latino or Hispanic ethnicity is much lower in North Carolina, despite a steady growth in our younger Latino population.

Table 1. North Carolina's Profile in Comparison to the US

	NC	US
Population 65+ in 2005[a]	1,054,098	36,790,113
Percent of population 65+ in 2005[a]	12.1	12.4
Percent of population 85+ in 2005[a]	1.5	1.7
Percent of persons 65+ who are:		
Women[a]	58.9	58.1
African American[a]	15.7	8.3
Latino[a]	1.1	6.2
Life expectancy at birth in 2000[b]	75.6	76.9
Life expectancy at 60 (additional years) in 2000[b]	20.8	21.6
Percent of population 65+ employed[c]	14.9	14.1
Percent of population 65+ in the labor force[c]	15.4	14.7
Percent of population 65+ who have worked in the past 12 months	19.0	18.1
Percent of population 65+ with less than a high school diploma[c]	32.8	27.5
Median income for households with heads ages 65+ for 2004, in 2005 inflation-adjusted dollars[c]	$26,156	$28,722
Percent 65+ below poverty[c]	11.7	9.9
Percent rural farm (all ages)[d]	1.0	1.1
Percent rural nonfarm (all ages)[d]	38.8	19.9
United Health Foundation rankings on overall health 2006 (all ages)[e]	36th—4.3% below the national average	

[a] US Census Bureau 2006. Population Estimates. Population for States by 5-year age group File: stterr2005.xls:2005-50+x5 and related tables by gender and ethnicity
[b] NCDPH 2002, *Healthy life expectancy in North Carolina,* 1996–2000.
[c] US Census Bureau, 2006. American Community Survey, 2005
[d] US Census Bureau, 2002. Summary File 3
[e] United Health Foundation (2006). *America's Health Rankings: A Call to Action for People & Their Communities.* Downloaded from http://www.unitedhealthfoundation/ahr2006.

In measures of well-being, the general trend is that older adults in North Carolina are slightly disadvantaged. This is shown in lower life expectancy, lower household income, higher poverty rates, and a larger percentage with less than a high school diploma. Perhaps because of lower average income, NC older adults are a little more likely to be employed or looking for work (both groups are counted in the labor force) than those in the US as a whole. At least part of this disadvantage is attributable to the difference in composition. North Carolina has more older women and older African Americans, and both of these groups continue to have higher rates of poverty, lower incomes, and health disparities. In other areas—education and life expectancy—there are gaps between White and African American elders, but women fare better than men. Until these historic disparities are reduced, North Carolina will lag behind the country.

Diversity among older adults

In the first pages of this chapter we have followed the common practice of representing older adults (60 and older or 65 and older) as one group. However, elders are as diverse, if not more diverse, than members of any other age group.

Ethnicity and gender. When we speak of diversity, many people think first of racial or ethnic diversity. Altogether 18.7 percent of people 65 and older in North Carolina are members of ethnic minority groups—15.7 percent African American, and 1.1 percent Latino. American Indians, Asian Americans, and other ethnic groups together account for 1.9 percent of the age group 65 and older. Older women represent 58.9 percent of people 65 and over and 71.1 percent of those 85 and over. This diversity of ethnicity and gender is important for two reasons. First, as mentioned earlier, women and members of most minority groups continue to be more likely to live in poverty, to live without a spouse (which has economic repercussions), and to be more vulnerable to some health conditions. This means that large numbers of older adults in these groups will likely increase the need for supportive community services. Secondly, as we work toward livable and senior-friendly communities, we will want to consider both the interests shared by all groups and interests and needs that may be more specific to each group. For example, women in the community may be more concerned with street lighting and other safety issues than their male counterparts. Older Latinos are less likely to read English than their younger family members and may especially need materials in Spanish, while older African Americans and American Indians may be concerned that community activities and facilities reflect the interests and contributions of their respective cultures.

Age diversity. We speak of everyone 60 and over (or 65 and over) as "older adults" or "elders" or "seniors," just as we sometimes speak of everyone from birth to 18 as children. This is statistically convenient but relatively meaningless for a variety of reasons. In fact, it is almost as difficult to talk about "older adults" and encompass the characteristics and needs of 60-year-olds and centenarians as it is to talk about "children" and encompass the characteristics and needs of infants and college freshmen. In the remaining pages of this chapter we will focus on the differences among the younger and older members of the population 65 and older and, as data permits, we will also address the differences between those groups and the 45 to 64 age group. This younger age group approximates the baby boomer cohort, but it is chosen because of how public data have been made available. In actuality, in 2005 (the date for most of the data used in this chapter) the boomers were ages 41 through 59, so this omits the youngest 4 years of boomers and includes 5 years of the generation born immediately before and during World War II. However, it does represent the group that will turn 65 over the next 20 years.

Why does age diversity matter for the *State Aging Services Plan?* Beyond a desire to present a profile of the older population that

is as accurate as possible, the members of these diverse groups have different service needs and different interests and resources to contribute to senior-friendly and livable communities. To take parks and greenway trails as an example, many boomers and "young older adults" want trails that are long enough to be challenging as they become more interested in keeping fit as a way to reduce the physical toll of aging. A number of slightly older elders may still want walking trails, but may need benches distributed relatively close together to permit resting along the way. The oldest old may want places where they can sit, with very little walking, and see some of the natural beauty that the trail walkers are enjoying. Of course, there have been 85-year-olds who have walked the Appalachian Trail from start to finish and there are boomers and even very young adults who are unable to walk at all, but on average their interest in walking trails may be expected to vary in these ways.

Why do we see differences among the age groups?

Time influences groups of people in three different ways—age-related human development, history, and cohort effects. In order to make sense out of the differences we see between boomers, the so-called young-old, and the oldest-old, we need to understand these different factors.

Age-related human development produces changes in individuals just as a result of living a longer time. For example, as people grow older they have larger vocabularies and broader life experience, but they also have a greater likelihood of having arthritis. When a difference is due to age-related development, we expect that each group of people who reach that age will have a similar experience.

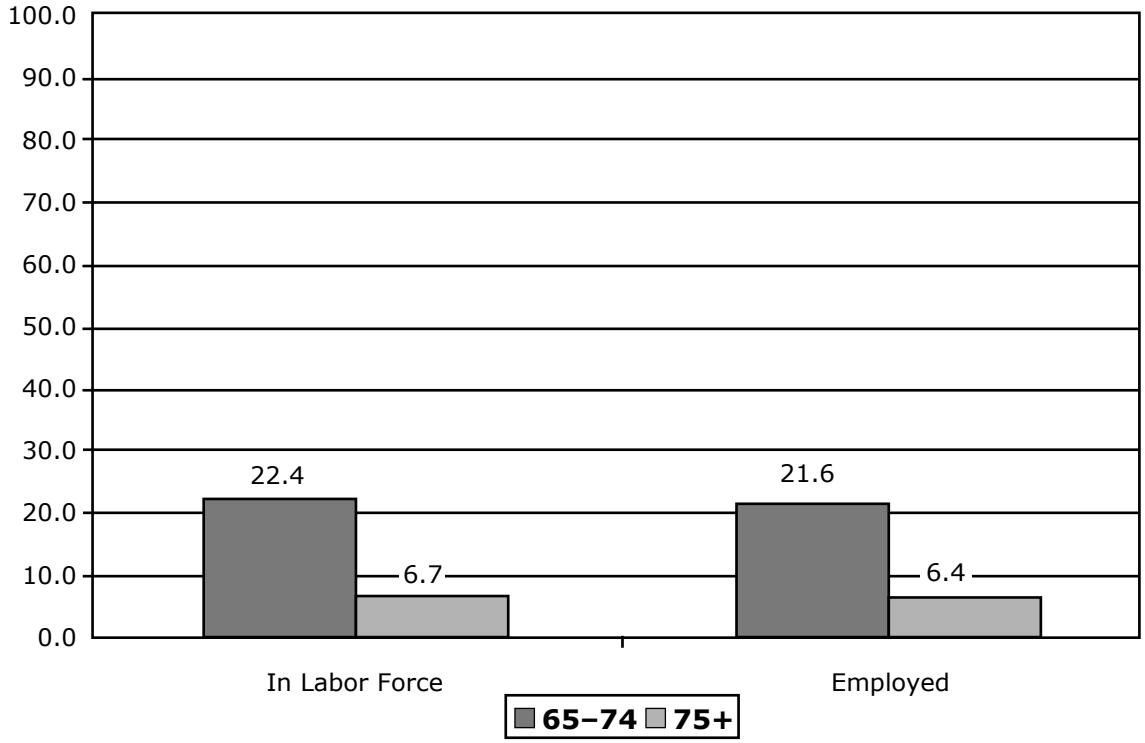
History is the impact of a change in world events, technology, customs, or policy. For example, we have already discussed how the Great Depression and World War II influenced the number of children born in those years.

Cohorts refer to groups of people who experience the same major event (e.g., birth, graduation, first marriage) in the same year or set of years. Cohort effects refer to differences in people according to what was happening in the years they reached certain milestones in their lives. For example, different birth cohorts have different percentages of people who never marry, depending on historical events that influence either desire or opportunity. Women reaching typical ages for marriage during the Depression had a higher likelihood of never marrying than the women before or after them because more men felt they could not afford to marry. When the economy improved after the War, some of those men married late, but they married younger women rather than women of their own age group. Older boomers also had a slightly higher rate of not marrying, but their reasons were largely different. Many of those who did not marry chose that option for career reasons or for greater independence. Of course people in every generation have many different reasons for marrying or not marrying, but we are talking about averages and trends.

How do today's older adults differ among themselves and as compared to younger adults?

Social and economic indicators: Employment, education, income, poverty, and marital status. Figure 3, which shows labor force participation and employment for two age groups, provides an example of an aging-related change after the usual age of retirement. The idea of 65 as the age of retirement is a product of history. It became nationally institutionalized with the advent of Social Security. Over the years, most company pensions followed suit. Another historical event, the establishment of a phased-in increase in Social Security eligibility ages for the boomers, will bring an increase in labor force participation among those 65 to 69 in the future. However, if we look only at the time after retirement eligibility, we expect that the differences between those working at ages 65

Figure 3. Percent in Labor Force and Percent Employed, by Age Group, for the NC Population 65+ in 2005



to 74 and those working at ages 75 and older reflect declines in health and energy levels that come with aging, as well as the desire to devote remaining energy to family, fulfilling deferred dreams, and other interests that arise in later life.

Figure 3 suggests that working for pay remains a very real option for the young-old, to supplement income or because of a commitment to the particular work a person does, and senior-friendly and livable communities will need to provide appropriate employment opportunities. Many have speculated that boomers will work longer, even beyond the increased ages to qualify for Social Security, primarily because they have done a poorer job of saving for their retirement. Whether or not this is the case, it is likely that working for pay will remain a viable option only for a very small proportion of those over age 75.

By contrast to employment, which in older ages is primarily driven by aging itself, education is the result of what is called a "cohort effect." That is, the primary reason for differences is because of how people born in one time acted differently from those born in another time. Thus, in figure 4 on the following page, we see that almost a third of older adults (65+) did not finish high school or receive a GED. By contrast, less than 15 percent of those 45 to 64 were unable to finish high school, and more than half, responding to differences in opportunity and the economy, completed at least some college. This higher level of education will have implications for both services and livable and senior-friendly communities. Consumers will be better informed and less dependent on professionals to explain their options, but their demands for accurate and timely information on which to base decisions and for professional services tailored to their needs will likely increase. They will also have, on average, a wider range of professional experience and skills to bring to volunteer community activity. Still, as we anticipate this increased educational level in tomorrow's older adults, it is important not to neglect the needs of the nearly one out of seven who have not finished high school, some of whom will still be functionally illiterate.

Figure 4. Highest Level of Education Completed, by Age Group, for NC Population 45+ in 2005

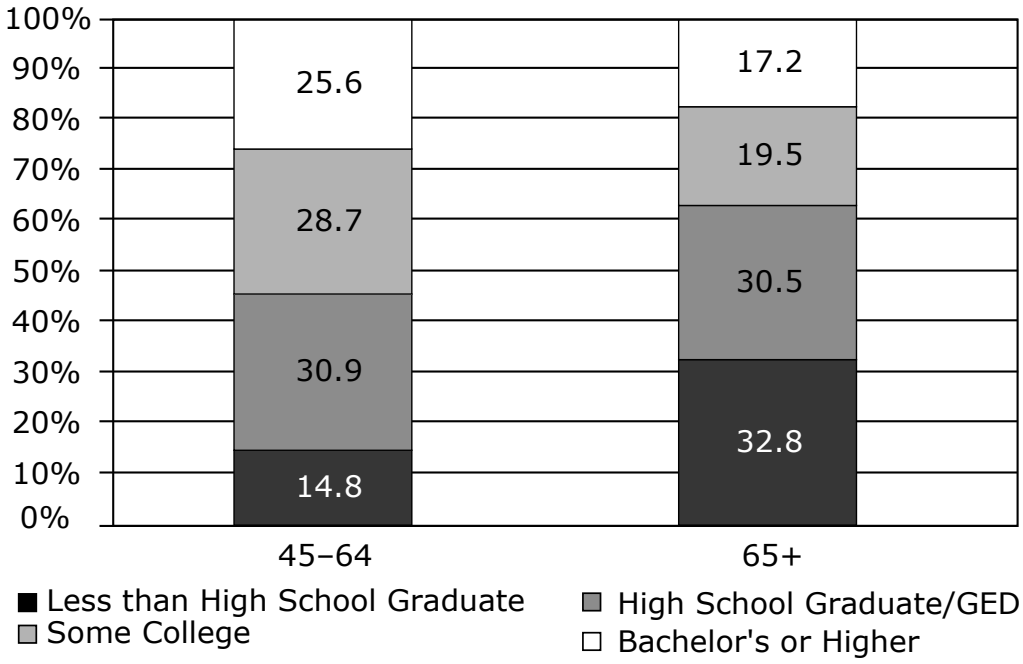
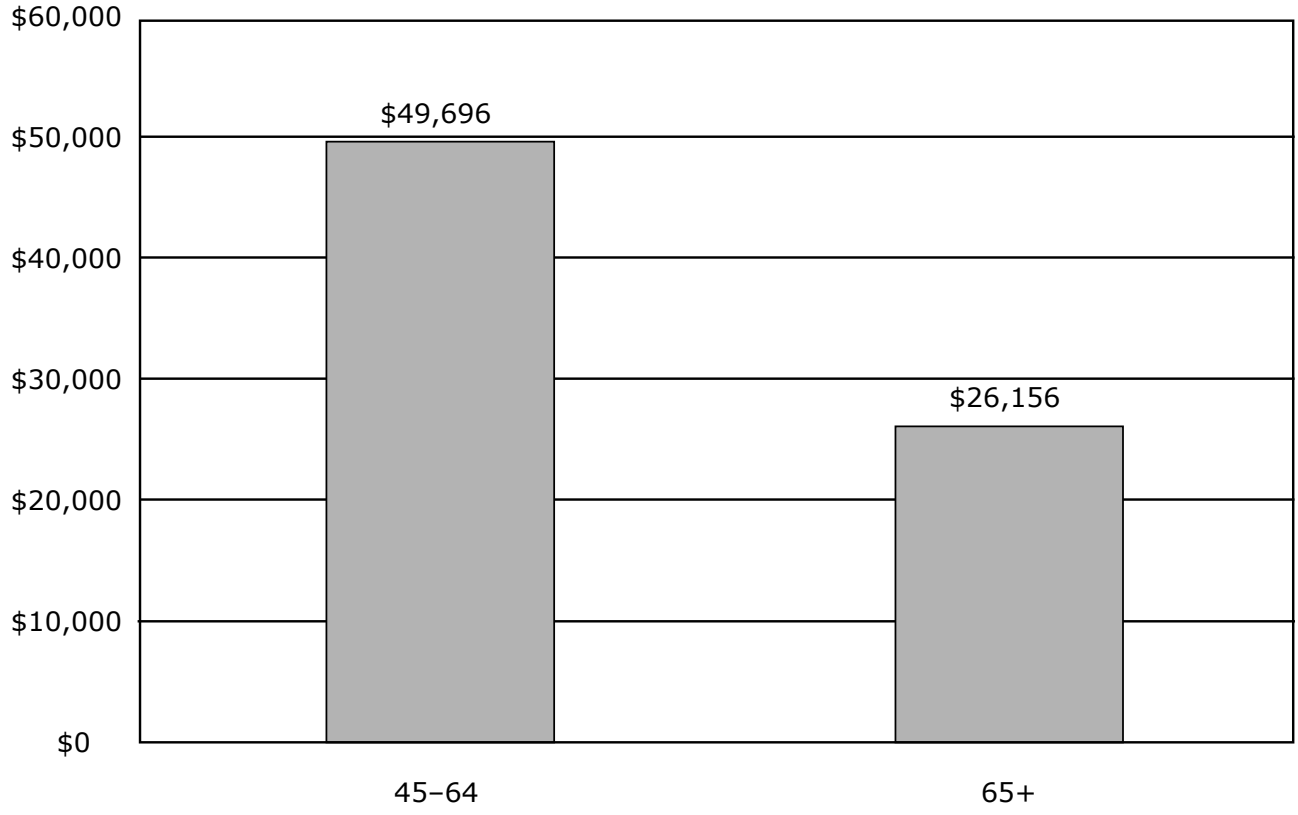


Figure 5. Median Household Income in 2004, by Age Group, for NC Population 45+ in Inflation-Adjusted 2005 Dollars



Most of the differences in median income shown in Figure 5 stem from aging-related changes, and thus will likely affect the next generation of elders in much the same way. Primary contributors are work status (see Figure 3), marital status (see Table 3), and the related difference in the number of households headed by women alone. On the other hand, cohort differences in earnings, savings, pension availability, and investments mean that we cannot be sure whether the boomer generation will have higher or lower constant-dollar household incomes when they retire. The American Community Survey does not provide more detailed breakdown of median income for ages after 65; however, data from the 2000 Census show that those over 75 have substantially lower median incomes than those 65 to 74.

Gender, race, and age group are all strongly related to whether income is above or below the poverty level. Table 2 shows poverty by gender and age group for the two largest racial groups in North Carolina. As that table shows, the primarily boomer group and the young-old have the same poverty rate, but underlying this is a reverse relationship between age and gender. Among men of both races, the younger group actually has a slightly higher poverty rate than the young old. By contrast, women ages 65 to 74 have a higher rate of poverty than women of the same race in the 45-to-64 age group. For both genders, poverty is highest for the age group 75 and older. Although this pattern is interesting and invites further analysis, the more striking fact in this table is the persistent higher prevalence of poverty for African Americans in both genders and every age group, culminating in the disturbing information that nearly a third of African American women age 75 and older are in poverty.

Table 2. Percent with Incomes below Poverty Level by Gender, Race, and Age Group for NC Population 45+, 2004 (reported in 2005)

Gender and Race	Percent in Poverty		
	Age Group		
	45–64	65–74	75+
African American men	16.4	15.6	25.4
White men	6.3	4.3	25.4
African American women	19.7	24.6	30.8
White women	7.1	8.8	15.3
All in age groups (African American and White	9.0	9.0	14.9

Table 3 presents marital status by gender and age. There are cohort differences that affect marital status, such as differences in the numbers who never marry, discussed earlier in this chapter, and the increasing acceptability and prevalence of divorce in the boomer cohort. However, aging brings the increasing likelihood of widowhood, especially for women. Aging also changes the distribution of marital status. For example, because on average married people live longer, the fact that there were a relatively large number who never married in the group age 85 and over is obscured by the smaller number of that group who lived to those ages.

Table 3. Percent in Each Marital Status by Gender and Age Group for NC Population 45+, 2005

	Never Married %	Now Married* %	Divorced & Separated %	Widowed %
Men 45–64	8.6	72.9	16.7	1.8
Men 65–74	3.0	79.1	10.7	7.2
Men 75–84	2.3	74.0	5.4	18.3
Men 85+	1.4	58.6	1.7	38.3
Women 45–64	6.8	65.1	21.6	6.5
Women 65–74	3.3	55.0	12.2	29.5
Women 75–84	2.3	35.0	6.3	56.4
Women 85+	4.1	10.4	4.4	81.1

*Includes couples living apart for reasons other than legal separation.

What are the implications for services and senior-friendly and livable communities of the figures in Table 3? Primarily, we can expect that when they reach the older adult years, the boomer generation will continue today's trend of large numbers of unmarried older women. In fact, the numbers may be larger, because at least some of the 21.6 percent divorced or separated will still be divorced when they reach retirement age. Women without spouses are more financially vulnerable and they also make more demands on the formal care system as well as on their children, because they lack spouses to provide care. On the other hand, older single women (never married, divorced, or widowed) are a great community resource as workers, volunteers, and family care providers.

Disability. In North Carolina, 43.0 percent of the noninstitutionalized civilian population 65 and older reported having one or more disabilities by the US Census definition—44.4 percent of women and 41.0 percent of men, according to the 2005 American Community Survey. The Census Bureau defines disability as "a long-lasting physical, mental, or emotional condition that makes it difficult for a person to do activities such as walking, climbing stairs, dressing, bathing, learning, or remembering. This condition can also impede a person from being able to go outside the home alone or to work at a job or business." Sensory disability, defined as "blindness, deafness, severe vision or hearing impairment," is also counted in the broad generalization of disability.

This definition of a long-lasting condition that creates difficulties is very broad and leads to counting a number of people who, indeed, have difficulties but are able to function independently and would not meet the average person's perception of someone with a disability. Despite the limitations of these data, they are the best national count available and a number of organizations that work with people with disabilities use these estimates. Figure 6 shows the proportion, by age group, who have any disability and the smaller subsets who have sensory disabilities and mental health disabilities. Disability data are not available for the comparison group 45 to 64 that we used in the social and economic indicators above, so the comparison is to all younger adults 21 to 64. As that figure shows, less than 15 percent of the younger age group had any disability, while among those age 75 and older, more than 55 percent have some level of disability. There is some evidence that the rate of disability associ-

ated with aging is declining, but we anticipate that the later years will continue to be a time in which people are highly vulnerable to disability.

Figure 6 also shows that more than one in four North Carolinians 75 and older have severe visual and/or hearing impairment, compared to only 11 percent of people 65 to 74 and less than 4 percent of younger adults (21 to 64). The nature and causes of sensory disability and the most desirable ways of functioning with these disabilities are sometimes not the same for the young and old, and this is particularly true for the sensory disabilities. For example those who lose hearing in later life very rarely learn to sign, and those who lose vision in older ages are less likely than their younger compatriots to learn to read Braille. Nonetheless, the livable and senior-friendly community is one with ample accommodation for those with disabilities in all age groups.

Mental health disability also increases with age, although this assumption can be clouded by disagreements about whether dementias are considered mental health disabilities. In the relatively near future, probably within the term of this *Plan*, we will see an increase in the number of older adults seeking help from the mental health system. This is because the stigma of mental health treatment is considerably lower for the boomer generation than for the generations that preceded them. A person who is 72 years old and struggling with depression or anxiety today is most likely to seek help from his primary care physician, but a similar person 10 years from now may well seek help from a mental health professional. It is therefore imperative that livable and senior-friendly communities include trained geriatric mental health professionals.

Figure 6. Percent with Any Disability, with Sensory Disability, and with Mental Health Disability (Census Bureau Definitions), by Age Group, for NC Population 21+, 2005

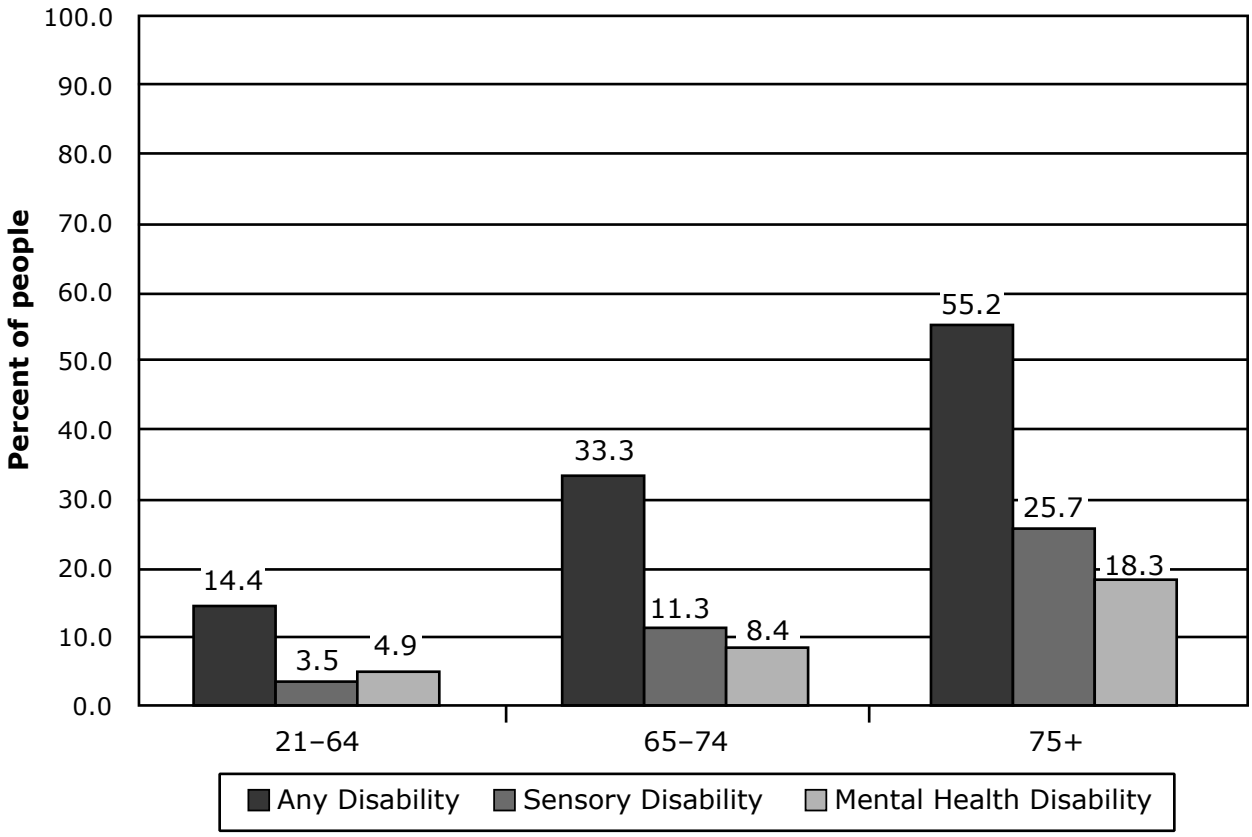
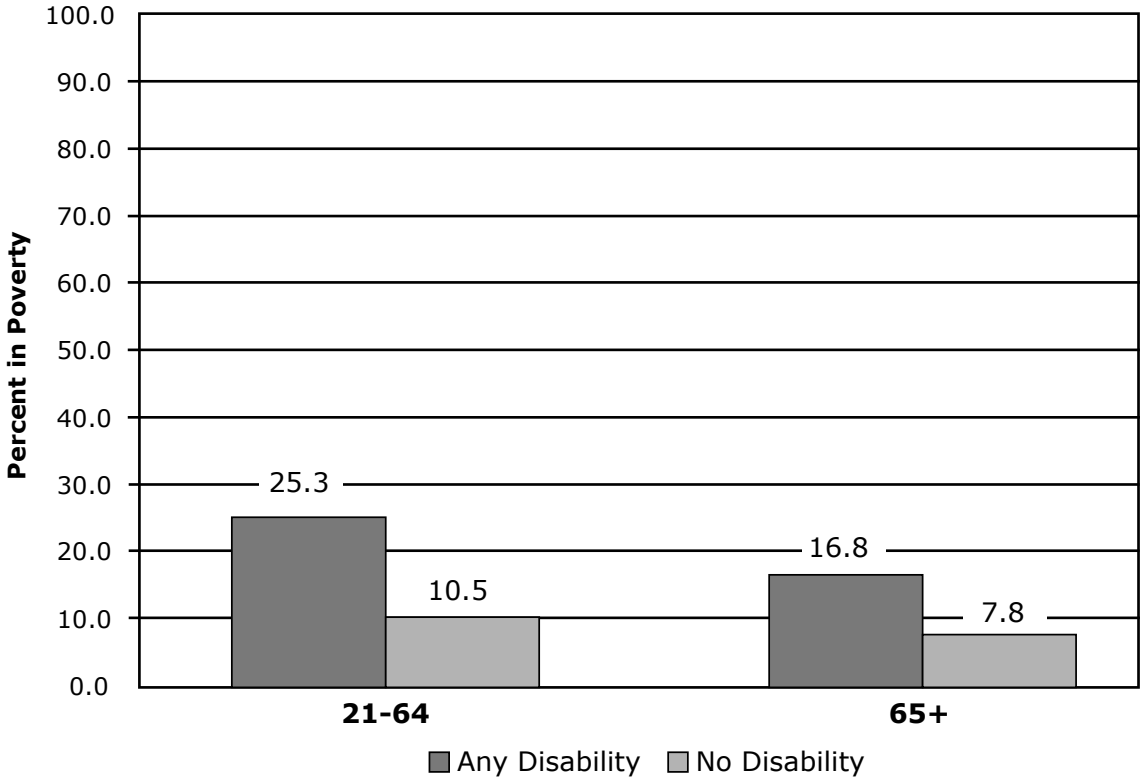


Figure 7 illustrates another key consideration about the higher rates of disability among older adults. Within each of the adult age groups for which data are available, those with disabilities are more than twice as likely to have incomes below the poverty level than those without disabilities. The poverty rates are higher for the younger ages, when we include the very young adults, for those with and without disabilities. This is most likely due to the protective value of Social Security and Supplementary Security Income (SSI) for those 65 and older. While there are also Social Security and employment programs for people with disabilities below age 65, these are not nearly so universal, and many people whose ability to earn money is compromised are unable to qualify for assistance.

Figure 7. Percent with 2004 Income below Poverty, by Disability Status and Age Group, for NC Population 21+, 2005



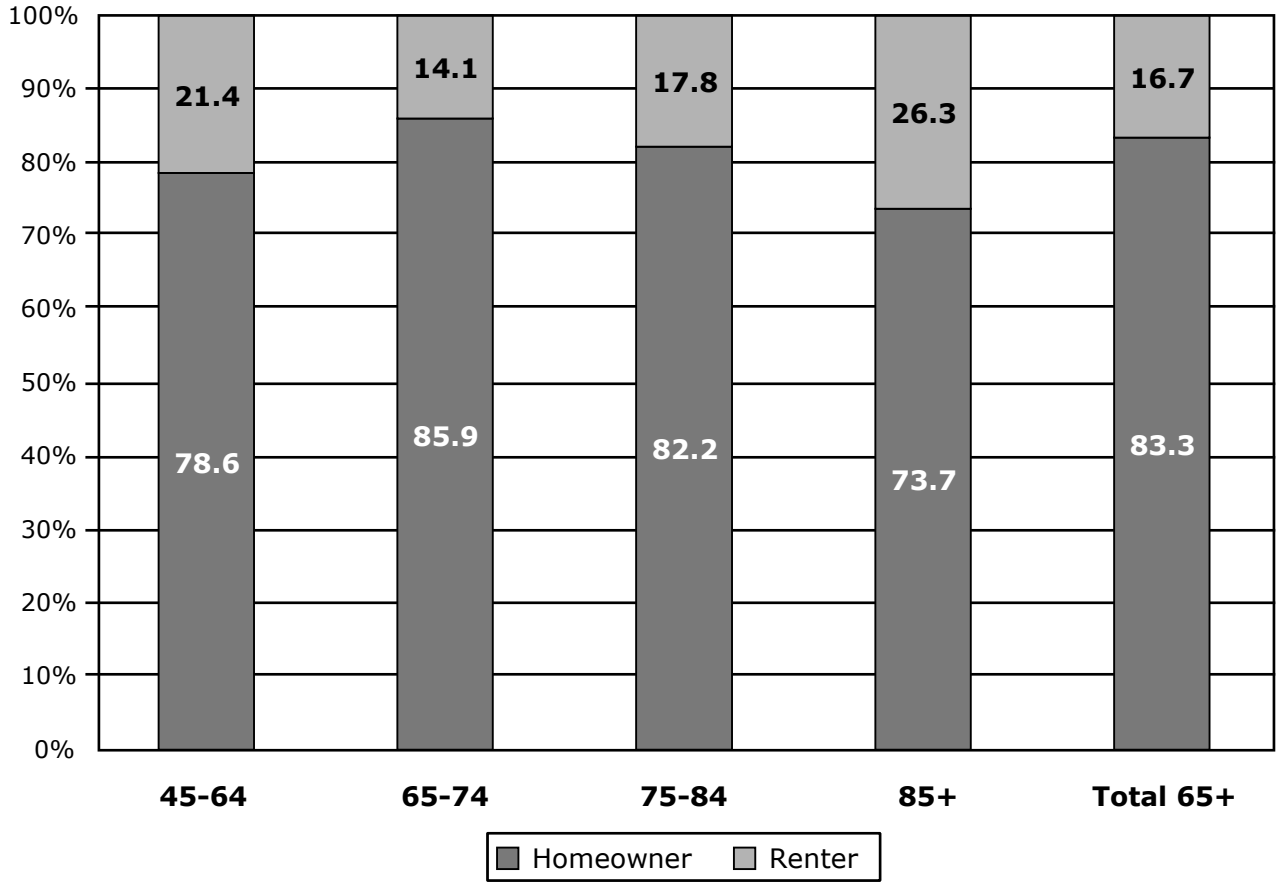
Information on Housing Units. Housing and transportation are key elements of a livable and senior-friendly community, and both the 2000 Census and the 2005 American Community Survey provide small amounts of provocative data on these elements. Housing units include all the forms of housing that are not residential facilities or group quarters, including houses, apartments, town homes, and mobile homes. The 2000 Census showed that in North Carolina, 81.4 percent of householders 65 and older owned their homes (with or without mortgage), yet among homeowners in that age group, over 61,000 reported incomes for 1999 that were below poverty. This figure means that in 1999, 11.8 percent of the homeowners over age 65 were poor, compared to 7.5 percent for homeowners of all age groups. In 2005, 83.3 percent of those 65 and over owned their homes, but as Figure 8 shows, that number is

less than 74 percent for the oldest old. North Carolinians ages 45 to 64 in 2005 were slightly less likely than older adults, as a group, to own a home, although more than three quarters did so. Poverty figures by home ownership are not available for 2005.

This wide home ownership has implications for helping some older adults be responsible for their own needs (e.g., through reverse mortgages). It is troubling that because somewhat fewer boomers own their own homes fewer of them will be able to take advantage of home equity when they retire. At the same time, the rate of poverty among older homeowners suggests the need for property tax relief for them.

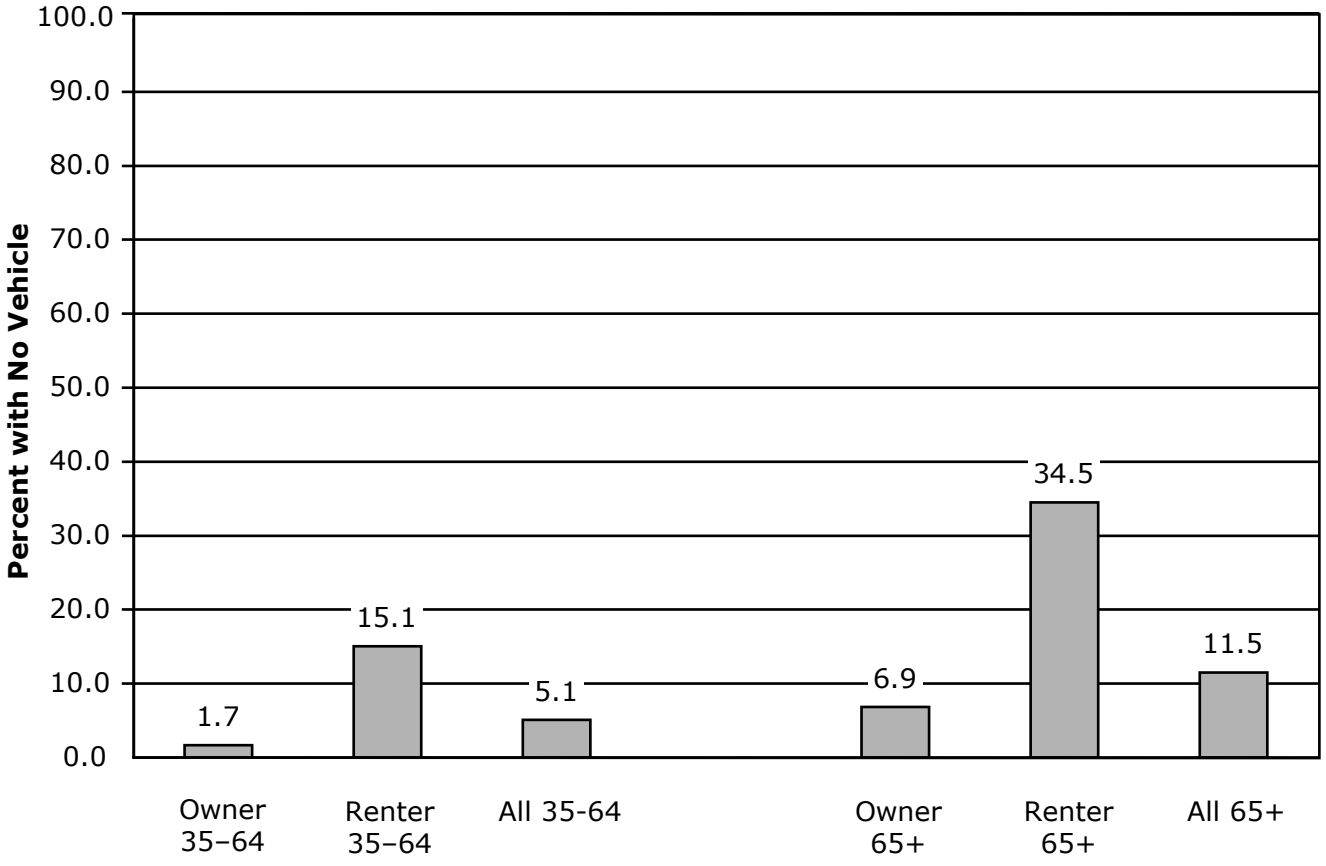
It is likely that renters have even lower income, although this information is not available for 2005. It is known that among renters 65 and older in 2005 who provided information, 57.7 percent, or 48,846 households, spent 30 percent or more of their household income on rent.

Figure 8. Percent of Housing Units Owned or Rented by Householder's Age Group, for NC Population 45+, 2005



As shown in Figure 9, the American Community Survey also provides information on the availability of one or more vehicles for each housing unit. However, the data were available for the age group 35 to 64 instead of 45 to 64, so the figure uses that somewhat larger comparison group. Figure 9 shows that older adults are more likely than the younger group to live in households with no motor vehicles, and that in both age groups, people who rent their homes are more likely than homeowners to have no access to a vehicle. In fact, more than a third of renters age 65 and older are without vehicles in their household. Of course some explanation of the greater number without vehicles in the older age group is that older people who are no longer able to drive sell or give away their cars, but the difference between owners and renters suggests that at least some of the lack is due to financial hardship.

Figure 9. Percent of Housing Units with No Vehicle Available by Ownership Status and Householder's Age Group, for NC Population 35+, 2005



Conclusions

Like the rest of the country, North Carolina is experiencing the calm before the storm as the size of the population 65 and older is relatively stable between two periods of unprecedented growth. It is serving a frail group of the oldest old and preparing for the retirement of the boomers. Compared to the US, older NC adults are similar but slightly more disadvantaged in income, education, and life expectancy. This disadvantaged status reflects the continuing disparity between African American and White North Carolinians and, to a lesser extent, between men and women.

Boomers are better educated than the current group of older adults but have slightly lower rates of home ownership. The oldest old are the group with the greatest likelihood of poverty, the lowest percentage still married, the largest majority of women, the highest rate of disability (mental health, sensory, and overall), and the lowest rate of home ownership.

These social and economic characteristics of older adult and boomer populations have implications for the development of livable and senior-friendly communities that is the focus of this *Aging Services Plan*.

II. Putting the Pieces Together: Building Livable and Senior-Friendly Communities

Livability and senior-friendliness mean different things to different people. Everyone wants to live in a friendly and livable place, but each of us has our own idea of what such a place should be. Our image of a livable community is shaped, in part, by our present and past experiences with communities we felt were desirable, comfortable, and safe, and that met our needs. As we age, our definition of livability begins to change to incorporate senior-friendly features. Primarily, older residents desire to remain as independent and have as many choices as possible to keep the quality of their lives at the highest level.

Livable and senior-friendly communities are places that are suitable for people of all ages. No one construct characterizes them all, but there are common elements of these communities: affordable and appropriate housing, accessible transportation, nearby shopping and services, job opportunities, and recreation and positive intergenerational exchanges, among others. These features encourage independence and support participation in civic and social life—keys to successful aging and a high quality of life for everyone.

Why was this framework chosen for the Plan?

As Chapter I illustrated, North Carolina's older population is not only increasing but is truly diverse. To be livable and senior-friendly, communities must accommodate the diversity of their residents. The livable and senior-friendly communities initiative, created by the Division of Aging (as it was then known) as part of the *2003–2007 State Aging Services Plan*, provides a very practical, tested framework to enable places in North Carolina, regardless of their size, to respond to the changing and unique needs and wants of their older population as well as accommodate residents of all ages.

The title, *Putting the Pieces Together*, connects this document to the original concept and most specifically to a brochure of the same name that introduced the concept to the public. By linking the pieces—that is, the objectives within each component of the livable and senior-friendly communities framework—the result should be a more seamless, comprehensive, and integrated approach to meeting the needs of older North Carolinians and engaging them more fully in their communities.

Definition and vision

The concept of a livable and senior-friendly community is one shared and molded by many different groups and organizations across the country. We find it under many different names, including an elder-friendly community, a senior-ready community, a livable community for older adults, a community for all ages, community for a lifetime, people-friendly communities, aging-friendly communities, and many more. What they share is the common goal of creating a good place to grow up and grow old.

Using this framework to develop the 40 objectives of the *Plan* is setting North Carolina apart from other states. We are charting a course toward realizing our vision of supporting the State's diverse communities in improving the lives of all people, and especially seniors. The vision, as developed by DAAS in the *2003–2007 Plan*, remains our touchstone for helping communities across North Carolina to:

- promote social and economic security for all citizens
- celebrate seniors' contributions to the community
- inspire intergenerational relations
- encourage community planners to involve seniors and consider their needs and interests
- affirm senior efforts to live independently and build responsive systems of long-term care for people of all ages
- acknowledge the important role that families, friends, and neighbors play in the lives of seniors, and enhance their capacity for caring.

Ties with national initiatives

While North Carolina is becoming a leader in the promotion of livable and senior-friendly communities, there are a number of other initiatives, programs, and projects in NC and elsewhere in the US that parallel aspects of this initiative. Although some are known by names that do not make the connection immediately obvious, they all have a common theme: making places better for living, working, and recreation. These initiatives together, when implemented, should result in certain desired common characteristics among places. The following list of initiatives is not intended to be exhaustive but illustrates how North Carolina's efforts fit into a national drive toward livability and senior-friendliness.

Americans with Disabilities Act. The American with Disabilities Act of 1990, which took effect in 1992, mandates that places available to the public shall be made accessible to all people. As a follow-up to this important legislation, in October 2006 the National Council on Disability developed a report entitled *Creating Livable Communities*, detailing strategies to improve community livability for people with disabilities.

Smart Growth. In the 1990s, the smart growth movement began to take root in urban planning and design. It incorporated principles that would result in the creation of new communities and maintenance of existing ones that are more attractive, convenient, safe, and healthy. These principles foster design that encourages social, civic, and physical activity. They can protect the environment while stimulating economic growth. Most of all, they can create more choices for residents, workers,

visitors, children, families, single people, and older adults about where to live, how to get around, and how to interact with people around them. Additional principles include encouraging mixed land use, creating walkable communities, providing a range and variety of housing and transportation choices, demanding greater public participation in the planning process, and using community design for active lifestyles.

AARP and Partners for Livable Communities. In 2000, AARP published *Livable Communities: An Evaluation Guide* so that older volunteers and other interested community members could assess the capacity of their community to meet the needs of older adults. In 2005 after 14 focus groups with older residents and their caregivers in 13 cities, the document was updated to include refinements to the earlier guide, as well as success stories, follow-up contact information, and references. Most recently, AARP has published *Beyond 50.05—A Report to the Nation on Livable Communities: Creating Environments for Successful Aging.*

US Administration on Aging's Choices for Independence Initiative. This initiative, the principles of which are included in the newly enacted Older Americans Act Amendments of 2006, is a key component of ongoing efforts to modernize and rebalance the nation's long-term care system. The three basic themes of the initiative include giving greater emphasis to high-quality home- and community-based services, deploying evidence-based health promotion, and offering older adults and their families seamless and understandable access to information about choices for health and long-term care options. In fall 2006, North Carolina's Department of Health and Human Services was the recipient of a $2.3 million Systems Transformation Grant from AoA to address some of the issues related to long-term services and supports in North Carolina.

2005 White House Conference on Aging. The White House Conference on Aging is a decennial event designed to make policy recommendations to the President and Congress about the needs of older Americans and to spur both branches of government to action. Held in December 2005 in Washington, DC, the delegates from across the US selected the following resolution to be in the top tier of recommendations: "Encourage community designs to promote livable communities that enable aging in place." The delegates adopted many more resolutions encouraging changes that would make communities more livable and senior-friendly.

The Maturing of America: Getting Communities on Track for an Aging Population. Five national organizations joined forces to identify ways to prepare communities for the aging of the population. The project, led by the National Association of Area Agencies on Aging, surveyed 10,000 local governments to determine their "aging readiness" to provide programs, policies, and services that address the needs of older adults and their caregivers; to ensure that their communities are "livable" for persons of all ages; and to harness the talent, wisdom, and experience of older adults to contribute to the community at large. The survey found that less than half (46 percent) of the responding communities had begun to address the needs of the aging population. Mountain Mobility, Buncombe County's community transportation program, is highlighted in the final report. This program offers transportation for older adults, including door-to-door paratransit service and bus passes for seniors 60+ who need to obtain medical services.

Center for Universal Design at North Carolina State University. The principle underlying universal design is that products and places can be designed so that anyone—young or old, disabled or not—can use them without the need for adaptation or customized design. It focuses on the microenvironment—the interior design of buildings, as well as the immediate space surrounding them. Because it fits the

environment to the person, rather than requiring that the person adapt to the environment, it enables people to age in place—that is, remain in their homes and live more independently for a longer time. This is important to the concept of successful aging, not only because it enables people to live at home, where most would prefer to stay, but it can prevent or delay a move to a long-term care facility.

History

Until the *2003–2007 State Aging Services Plan*, little attention and discussion had centered on the livability and senior-friendliness of communities in North Carolina. Staff members at the Division of Aging noticed that while the proportion of seniors was growing in many counties and communities, few places were planning to meet the unique needs of their increasing numbers of older residents. To support living in place, active aging, and maintaining quality of life, the Division introduced the concept in the *2003–2007 Plan*. It was known then simply as "senior-friendly communities," and the division dedicated a chapter to this goal.

Rather quickly, interest in the vision of senior-friendly communities grew across the State as directors of the area agencies on aging, senior center directors, cooperative extension agents, and many others began to use the concept to raise awareness among elected and appointed officials, advocates, service providers, planners, consumers, civic leaders, and the general public about the importance of preparing communities for the changing demographics. They are continuing to offer workshops; create local collaborative efforts in such areas as senior-friendly businesses and community walkability audits; and develop tools to help with understanding, envisioning, and assessing how communities can better prepare for an aging population.

During 2004–05, DAAS conducted a series of focus groups with various stakeholders in six counties to glean ideas on how best to promote the concept statewide. As a result of these and other discussions, the name was changed to "livable and senior-friendly communities." "Livable" was added to acknowledge that many aspects of the vision are relevant and appeal to people of all ages and circumstances. This change has extended the scope of the initiative, inviting many more partners, and has made it more compatible with similar initiatives both at the national and state levels. At the same time, DAAS affirmed from the focus groups the importance of still recognizing and responding to specific senior needs and interests—hence, the dual name. The word "communities" still expresses the division's vision that this initiative must go well beyond government agencies and aging services and programs to include all sectors, with a particular emphasis on local activity.

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COMMUNITIES
NORTH CAROLINA

It was also during this time that the logo for livable and senior-friendly communities was developed to be used by the division and other organizations in promoting the concept among potential partners. Much thought went into the creation of a logo that would help affirm the concept and initiative, that was adaptable for use by various organizations, and that had varying print capabilities as well as readability.

In 2005, three senior centers began livable and senior-friendly pilot projects. The purpose of the pilots was to enhance their respective community's "livability and senior-friendliness in one specific area; to explore on a small scale how senior centers might work in their communities to further the concept; and to determine possible roles for senior centers in promoting, marketing, advocating, and encour-

aging their communities to become more livable and senior-friendly through social entrepreneurship." Each selected a different area of focus: The NASH in Nash County worked to strengthen the senior-friendliness of businesses; Franklinton Senior Center in Franklin County emphasized home safety; and Roy B. Culler Senior Center in Guilford County addressed the senior-friendliness of the arts. These three centers joined with DAAS in conducting a major training session for NC's senior centers on livable and senior-friendly communities. Staff of more than 70 senior centers attending considered how their centers could serve as focal points and catalysts for engaging their communities in this initiative.

Elsewhere in the State, other communities and groups are campaigning to educate, plan, and influence policy and practice. For example, Mecklenburg County framed its *Status of Seniors* initiative in terms of the livable and senior-friendly framework; Henderson County is working with the UNC Institute on Aging and the Highway Safety Research Center to promote safety for senior pedestrians; and Wilson County held forums to identify priorities for creating more livable and senior-friendly communities. These are but a few of the growing and varied ways that communities and organizations are responding.

Components

There are many dimensions to developing a community that promotes quality of life for all citizens, including seniors. It is hard to imagine any aspect of society that is not affected by our demographic shift. Listed below are the major components of livability and senior-friendliness that DAAS is encouraging communities to consider when evaluating their readiness for an aging population. These components provide the framework for this *Plan* and its 40 objectives.

A brief description of each component is given before each section in Chapter III. Included within each component are elements that can further indicate how a place needs to prepare to accommodate older persons. Certainly, there are other criteria as well that can help a community guide and measure its readiness for older residents. Still the eight components and their elements (as presented below)—separate and interrelated as they are—provide a useful construct for discussion, planning, and action at the State and local levels.

Physical and Accessible Environment

Air and water quality
Housing and utilities
Land use
Neighborhood organization
Noise control
Recreational facilities
Road safety
Shopping
Transportation
Zoning

Healthy Aging

Adult immunization
Dental health
Hospitals
Leisure
Medicare and Medicaid acceptance
Medications
Mental health
Nutrition
Preventive care
Primary care
Rehabilitation
Vision and hearing care
Wellness and fitness

Economic Security

Age discrimination
Financial planning
Health care cost
Income
Job opportunities
Job retooling
Job training
Long-term care cost
Senior-friendly businesses
Tax credits and exemptions

Technology

Assistive and adaptive devices
Distance-learning
Internet access
Medical alert
Tele-medicine
Telephone and cell phone access

Safety and Security

Abuse and neglect
Domestic violence
Driver safety
Emergency response
Fire safety
Fraud and exploitation
Outreach

Public Accountability and Responsiveness

Community needs assessments
Planning and coordination
Program evaluation
Public and private funding sources
Public benefits
Representation in public affairs
Taxes

Social and Cultural Opportunity

The Arts
Community sensitivity
Cultural and social programs
Intergenerational relations
Libraries
Lifelong learning
Media
Racial, ethnic, and linguistic diversity
Spiritual growth
Volunteerism

Access and Choice in Services and Supports

Care management
Caregiver support
Drug assistance
End-of-life care
Grandparents raising grandchildren
Guardianship
Home and community services
Information and assistance (I&A)
Legal services
Long-term care facilities
Senior centers

Conclusion

Communities across North Carolina are faced with increasingly difficult choices and decisions about how to grow, plan for change, and improve the quality of life for all citizens, including children, young and old adults, and people with disabilities. Today, nearly every community in the State is seeing or will soon see greater numbers of seniors. With the drop in the number of births at the end of the Great Depression and during the war years, the period of this *Plan* is the lull before the long and rapid increase in older adults born between the boomer years of 1946 and 1964. Now is clearly a time we should devote to planning and preparedness.

Because the future interests of older adults, their families, and communities are at stake, we need to assure that the towns, cities, and counties within our State are livable and senior-friendly. We have a grand opportunity during the next four years to make major strides in promoting this concept statewide through the implementation of the 40 objectives contained in Chapter III.

By putting the pieces of the aging puzzle together through accomplishing these and other related objectives, North Carolina will continue positioning itself among the leading states making conscious efforts towards livability and senior-friendliness for everyone. Progress in all eight components of the livable and senior-friendly framework should strengthen the preparedness of communities to enhance the quality of life of today's older North Carolinians and their families, as well as improve the outlook for the future of aging boomers. The building of livable and senior-friendly communities will make our greater State community a far better place for us all.

III. Accomplishments and Objectives

The Division of Aging and Adult Services (DAAS) produces a *State Aging Services Plan* every four years, as required by North Carolina General Statute 143B-181.1A and the federal Older Americans Act. In keeping with the theme of this year's plan, *Putting the Pieces Together,* this chapter outlines two fundamental pieces—accomplishments since the *2003–2007 Plan* and objectives for the *2007–2011 Plan*. Both accomplishments and objectives reflect North Carolina's mission to enhance the quality of life of older adults by providing programs and supportive services to meet their needs and use their talents and interests.

DAAS worked with many State agencies and other organizations to identify accomplishments since the *2003–2007 Plan* (see Appendix A for Inventory of State Resources for Older Adults). DAAS staff members reviewed annual reports, newsletters, and other relevant publications, and solicited additional input from the organizations directly. There are certainly more accomplishments than can be presented in this short document. We have singled out some of the most significant, which are listed here under the eight components of the livable and senior-friendly communities framework.

In fall 2005, DAAS was the recipient of a Planning Grant from the US Administration on Aging. This three-year grant focuses on developing a comprehensive approach to planning for aging services throughout NC. The goal is to create a planning process that effectively integrates the three levels of government activity: local (county), regional, and state with an emphasis on local planning. Eventually, local plans will be included in the regional (area) plans prepared by the Area Agency on Aging (see Appendix B for the list of Area Agencies on Aging), which will flow into the objectives of the *State Plan.* Once accomplished, this "consumer-driven" process should provide for a more dynamic relationship among the various levels of planning and ultimately should facilitate a more comprehensive and better integrated provision of services for older citizens and their families.

Because this *2003–2007 Plan* is coming in the middle of the grant cycle, it is viewed as an "evolutionary" plan—one in which we have attempted to consider local level issues in developing the objectives contained in this document. Work on the Planning Grant is being done using the livable and senior-friendly communities framework; therefore, we believe this framework is a logical and useful foundation for the *State Plan* as well. For the past several months, DAAS staff have researched numerous documents and consulted with experts in various organizations to derive the 40 objectives included in the *Plan*.

Both accomplishments and objectives reflect North Carolina's mission to enhance the quality of life of older adults by providing programs and supportive services to meet their needs and use their talents and interests.

This planned and deliberate process involved:

- reviewing the 17 Area Plans and developing a list of Emerging Issues from an Assessment of Senior-Friendliness and Service Needs, which includes information received from each county within the regions (see Appendix C)
- analyzing the Emerging Issues to determine where the predominance of needs and interest lies within each of the eight components of the livable and senior-friendly communities model
- assessing the recommendations in the 2005 White House Conference on Aging proceedings and changes to the newly reauthorized Older Americans Act
- considering the Program Instructions for State Plans of the US Administration on Aging (AoA)
- communicating and collaborating with program specialists and other contacts both in and out of State government to get their input for the draft objectives and their commitment to collaborate in strategic planning and implementation (see Acknowledgments)
- reviewing appropriate planning and policy documents of other State agencies
- reviewing applicable grants and other projects
- considering various groups' recommendations for the 2007 Legislature (see the table in Appendix D).

DAAS staff members will continue to work with key contacts in the organizations that assisted in developing the objectives to increase the likelihood that we can list these objectives among our accomplishments in 2012. DAAS took the position of seeking broad input because we believe the more individuals who participate the greater likelihood that significant needs and concerns of older North Carolinians and their families will be addressed in the coming four years.

To facilitate the use of the *Plan*, a list of Acronyms and References is included in the Appendixes. Generally after initial use of the full name of the organization, the commonly known acronym for each has been used throughout Chapter III. A list of the acronyms is included in Appendix F. The complete references for all materials cited throughout the document are included in Appendix G.

Physical and Accessible Environment

The built and the natural environments together shape the experiences of older adults, from the microenvironment of the nursing home bed or private home to the macroenvironment of the neighborhood, town or city, county, and State. Among the factors that affect our environments are transportation and road safety, air and water quality, housing, and land use. How easily older people can navigate their environment has important consequences, not only for their personal independence but also for their ability to remain socially and physically active and connected. For many adults, getting there is half the battle, so several objectives in this section address transportation and driving. Having affordable housing that meets one's needs is even more crucial, whether one rents or owns.

Major Accomplishments (2003–2007)

- ✓ Two positions were established within DHHS to stimulate and coordinate interagency activities in housing and transportation—two of the most frequently cited barriers to people remaining in the community.
- ✓ DHHS received $775,000 over three years to implement the Integrating Long Term Supports with Affordable Housing Grant, which seeks to build local cross-agency infrastructure within both the disability service and affordable housing systems.
- ✓ In July 2006 the NC General Assembly created and funded the Housing 400 Initiative to increase the supply of "independent and supportive living apartments for persons with disabilities" through the collaborative efforts of the NCHFA and DHHS.
- ✓ The UNC Highway Safety Research Center, working with the community of Hendersonville, developed a model program to create safer and more inviting walking environments for older adults, and a number of communities have begun conducting walkability audits.
- ✓ DPH, working with the Healthy Carolinian network, has launched the *Eat Smart Move More* campaign (www.eatsmartmovemorenc.com), and supported development of active living environments.
- ✓ Support for public transportation services was significantly expanded in 2006 with a supplemental allocation of $5 million for the Elderly and Disabled Transportation Assistance Program and the Rural General Public Transportation Program.

Objectives (2007–2011)

1. DHHS and NCDOT will pilot a public information campaign with four or more county and regional partners to increase awareness among older adults and their families of the various public and private transportation options available in their service areas.
2. DAAS and NC4A will support local Aging Leadership Planning Teams that choose transportation as a focus of local planning by providing assistance with a transportation needs assessment and supporting the development of a transportation plan in coordination with local transportation planners.
3. The Senior Driver Safety Coalition will develop a website to educate the North Carolina public about safe driving issues, resources for driving safer longer, licensing requirements and restrictions, information for families concerned with the safety of an older driver, and transportation alternatives to keep nondrivers mobile.
4. North Carolina will have a dedicated revenue source to support a continuing Housing Trust Fund to address a range of high-priority housing needs for seniors and others with limited resources.
5. North Carolina will expand State-funded rental assistance programs to assist seniors and others with limited resources in affording safe, adequate, and accessible housing in their communities.

1. DHHS and NCDOT will pilot a public information campaign with four or more county and regional partners to increase awareness among older adults and their families of the various public and private transportation options available in their service areas.

North Carolina has 20 urban transit systems, 2 regional urban systems, 1 small urban system, 7 regional community transportation systems, 71 single-county systems, and 4 human service transportation systems, for a total of 105 transit systems across the State. Services are provided in all 100 NC counties and major urban areas. Operating statistics from the NC Department of Transportation (NCDOT) for all the systems indicate that more than 50.5 million rides are provided each year. A combination of federal, state, local, and fare-based funding has supported this distribution of transportation services across the State. Many areas also have taxis, private transportation companies, and volunteer transportation to supplement public services.

Despite NC's substantial transportation infrastructure, unserved and underserved areas still exist, and key informants have consistently identified transportation as a significant unmet need across the State. Almost one-fifth of North Carolinians over age 65 do not have driver's licenses. Loss of a driver's license, health problems that affect driving even temporarily, or the death of a spouse who was the primary driver for the household—these are all life-changing events for people who still have to buy groceries and go to health care appointments.

Explanations of unmet need often include lack of funding, lack of service options (e.g., services needed in locations or at times when they are not available), mismatches between users and services (e.g., desired destinations not necessarily allowed by funding sources), and user perceptions (e.g., fear of using public transportation). However, anecdotal information from agencies also suggests that older adults do not always know where to find transportation alternatives when they are unable to drive or lack access to a vehicle. Some of the unmet need among seniors can probably be addressed with a focused effort to distribute information about available resources.

While people may need more information about transportation alternatives, agencies understandably may be reluctant to advertise. Marketing their services could raise expectations about the availability of publicly-funded transportation when demand in many counties already exceeds available funding. In a no-win cycle of waiting lists and empty seats, transportation systems may be reluctant to experiment with service options.

Finding the right public awareness message that strikes a balance between informing and inflating expectations could be an important tactic for addressing this issue. Localities need straightforward models to affect users' perceptions about public transportation and increase public awareness of transportation resources.

2. DAAS and NC4A will support local Aging Leadership Planning Teams that choose transportation as a focus of local planning by providing assistance with a transportation needs assessment and supporting the development of a transportation plan in coordination with local transportation planners.

Since December 1978, when Governor James Hunt issued an Executive Order on coordination of human services transportation resources, North Carolina has steadily increased the level of cooperation among agencies that provide, arrange, or purchase transportation services. Each succeeding Governor has reissued an order that supports coordination of transportation resources. The current Executive Order requires that the "locally prepared and adopted Community Transportation Improvement Plan shall continue to be the means to determine the most cost effective and efficient use of transportation resources." This long history of working to maximize resources through improved coordination was recognized in 2004, when the Federal Transit Administration awarded NC one of its first five state Leadership Awards for United We Ride.

To make public transportation services responsive to the network of agencies that provide or arrange transportation for their clients, NCDOT requires local systems to include representation from core human service agencies (aging, social services, public health, area mental health, and area rehabilitative programs) on Transportation Advisory Boards and to execute a Memorandum of Understanding with core human service agencies that must be attached to applications for State funding. This has proven to be an effective means of assuring representation of these stakeholders in a comprehensive community planning process.

"Anything to strengthen safety and accessibility to transportation is a necessity. Transportation is an important factor to independence."

Jean Reaves, President
Coalition on Aging

Not all planning efforts are equally successful, however, even when willing partners come together to identify barriers and develop strategies. In support of communities that identify transportation as a focus of local planning, this objective of the *State Plan* is to assure that communities, whose local Aging Leadership Planning Teams focus on transportation, receive technical assistance and support from DAAS and DHHS as well as NCDOT.

3. The Senior Driver Safety Coalition will develop a web site to educate the North Carolina public about safe driving issues, resources for driving safer longer, licensing requirements and restrictions, information for families concerned with the safety of an older driver, and transportation alternatives to keep nondrivers mobile.

The US is a highly mobile society, with much of this mobility centered on private vehicles. The US has the highest per capita vehicle ownership of any country in the world. The American landscape, and in particular its extensive suburbs and expanses of rural farmland, make private vehicles the only practical transportation option for many people, but it is also true that the majority of Americans simply prefer the convenience and flexibility of a private vehicle. According to the most recent National Household Travel Survey data, 87 percent of all US trips are made by private vehicle.

Driving is important for our older adult population, and older adults are even more likely than younger ones to depend on private vehicles to meet their transportation needs. At the same time, chronic medical conditions and declining functional abilities can increase older adults' risk of unsafe driving. Eventually, many older adults will need to stop driving altogether. Foley and colleagues (2002) estimated that a 70-year-old man today will outlive his ability to drive by six years, while a 70-year-old woman will outlive her ability to drive by 10 years. When forced to stop driving, however, older adults still need access to services and to remain socially connected to their communities.

The North Carolina Senior Driver Safety Coalition (SDSC), which includes representatives from DAAS, AARP NC, AAA Carolinas, NCDOT, Division of Motor Vehicles, NC Medical Society, UNC School of Medicine, UNC Highway Safety Research Center, and other agencies and organizations uniquely qualified to address issues of older driver safety and mobility, has recommended developing a website with information about issues affecting older drivers and ways to prolong safe driving, modeled after websites already in place in other states. A group has already been formed to begin the work.

4. North Carolina will have a dedicated revenue source to support a continuing Housing Trust Fund to address a range of high-priority housing needs for seniors and others with limited resources.

In 1987, the Housing Trust Fund was established to address the problem of unaffordable housing, using funds from a legal settlement from the oil industry and, starting in 1990, appropriations from the General Assembly ranging up to $9 million yearly. Appropriations have fluctuated widely, and some years there have been no allocations, but the fund has averaged $3.6 million per year. The North Carolina Housing Finance Agency (HFA), which manages the fund, pays all administrative costs, and all trust fund money goes directly to improve housing in all 100 counties. The money is used to develop affordable, private-sector housing for people with low income, especially for seniors and others who may be disabled or homeless. Funds are also used to rehabilitate, repair, or make existing homes more accessible and to assist first-time homeowners.

Most older people do not move when they retire. Rather, they stay in the homes where they reared a family and have lived for many years. As AARP found when surveying seniors, 90 percent preferred to stay in their current home, with familiar neighbors in their community. Although some seniors move because of financial or medical considerations, widowhood, or to be closer to children, most stay where they are for as long as possible. That said, their own houses or apartments can pose problems for them. Many have difficulty making needed repairs and modifications to accommodate changing physical abilities and finding the way to pay for these repairs. Others have difficulty

carrying out the regular maintenance necessary to keep their homes safe. Older homeowners often live in older homes, which can be difficult and costly to maintain and to heat and cool. Substandard housing and lack of home modifications to accommodate changes in mobility are major threats to independence for many older North Carolinians. According to the 2000 Census, 128,400 senior households indicated housing problems, 104,100 households paid more than 30 percent of their income for housing, and 199,100 households had mobility or self-care limitations that housing modifications might ease.

There are several programs that help older North Carolinians with improving existing housing. Housing and Home Improvement services are provided by North Carolina's Home and Community Care Block Grant (HCCBG) administered by DAAS, and other programs are available through the US Department of Health and Human Services Office of Economic Opportunity, US Department of Agriculture, NC Department of Commerce Scattered Site Housing, and HFA Urgent Repair. In January 2007, however, there were 811 households on the HCCBG waiting list for housing and home improvement services and the situation is similar in the other programs.

The Housing Trust Fund has supported many beneficial projects across the State, but it is underfunded. With resources already inadequate and with the proportion of the NC older population growing, increasing numbers of seniors who are on fixed incomes will find it more difficult to live in safe, accessible, and affordable housing in the community, and some may be forced into unnecessary or premature placement in a facility. In the next four years, NC will focus on preserving existing affordable housing through rehabilitation and modification to improve accessibility. With an adequate, stable investment in the Housing Trust Fund that a dedicated revenue source would provide, these issues can be better addressed.

5. North Carolina will expand State-funded rental assistance programs to assist seniors and others with limited resources in affording safe, adequate, and accessible housing in their communities.

Rental assistance is the bridge between what a household can afford and what the local housing market requires in rent. Most rental assistance programs expect households to pay 30 percent of their adjusted income toward rent. Seniors with limited resources often require rental assistance to afford safe, adequate, and accessible rental units. According to the Social Security Administration, in 2004 there were 49,920 people 65 and older in NC receiving Supplemental Security Income (SSI), which was less than $600 per month for an individual and less than $870 per month for a couple. Funding support for rental assistance vouchers (i.e., Section 8) is far too small to assist every eligible household, and long or closed waiting lists at many housing authorities hinder access to timely rental assistance.

There are very few rental assistance programs in NC at this time. The Key Program, a partnership between HFA and DHHS, currently provides 10 years of rental assistance to the Internal Revenue Service (IRS) Low Income Housing Tax Credit properties. Since 2004, 10 percent of these units have been targeted to seniors and other persons with disabilities living on incomes as low as SSI. To date, over 900 units

The vast majority of seniors prefer to stay in their current homes with familiar neighbors and surroundings.

have been funded through the partnership, but this represents only a small fraction of the population that needs rental assistance to make up the difference between a reasonable share of their extremely low incomes and the cost of adequate rental housing.

Since 1990, the IRS Low Income Housing Tax Credit Program, administered by the HFA, has funded over 10,000 units for seniors at or below 60 percent of the area median income. The majority of these units, however, are not affordable to households with extremely low incomes. There is public housing—rental housing financed through HUD Section 202 and the US Department of Agriculture Rural Development—that incorporates subsidies that allow households to pay 30 percent of their income for housing costs. However, waiting lists for these units are long, especially in urban areas. The private-sector rental market has been a source of affordable housing for the few who have a Section 8 voucher, but federal cuts have reduced this opportunity for many people.

Evidence shows that funding and programs to assist older and disabled adults with limited resources fall far short of the need. As the population over age 60 increases, the situation will become worse. In the next four years North Carolina will focus on increasing rental assistance programs and construction of affordable rental housing. A State-funded rental assistance program, restoration to cuts in federal programs, and increased allocations for construction of affordable properties could relieve some of the strain on people whose struggle to pay for housing competes with their need for other basic necessities.

Healthy Aging

The United States is on the brink of a longevity revolution. Technological advances in medical care help people live longer, if not necessarily in better health. As boomers enter the years when more will begin to experience chronic diseases, helping them maintain good health becomes paramount, because their growing number will increase demands on State and local governments, the public health system, and medical and social services. Objectives in this section focus on teaching older adults to get access to public benefits that support their health, improving dental and mental health care, encouraging healthy life styles, and planning the care they would prefer in their last days.

Major Accomplishments (2003–2007)

- ✓ NC made extensive efforts to assist seniors with their medication needs, including expansion of NC Senior Care (the State's pharmacy assistance program) until Medicare Part D began. SHIIP and the Medicare Partners State Level Coordinating Committee led a massive, multi-agency education, outreach, and enrollment campaign for Medicare Part D; and NCRx and NCRx Care were developed to assist individuals with low incomes with Medicare Part D premiums and to support medication management.
- ✓ The NC Healthy Aging Coalition (NCHAC) was established in 2005 to create, strengthen, and sustain evidence-based programs, policies, and environments to foster healthy aging.
- ✓ Several reports were produced to aid in planning and education of consumers, advocates, and professionals about healthy aging, including *The Health Profile of Older North Carolinians* (www.schs.state.nc.us/SCHS/pdf/Elderly.pdf); an issue of the *NC Medical Journal* devoted to Alzheimer's disease and family caregiving (www.nciom.org)]; and the State's first status report on family caregiving, *Family Caregivers in North Carolina: What Do We Know? What Are We Doing to Help* (www.ncdhhs.gov/aging/fcaregr/Statusreport2005final.pdf), with a supplement on caregivers of people with Alzheimer's and other dementias.
- ✓ Efforts were advanced to assist persons with developmental disabilities in their aging, including grants awarded by the NC Council on Developmental Disabilities for its Aging: Doing It My Way initiative, and development of a Memorandum of Agreement among DAAS, DSS, and DMH/DD/SAS.
- ✓ Efforts to address health disparities included Project C.A.R.E., targeting minority, rural, and low-income family caregivers in 10 counties, and the Arthritis Foundation Exercise Program (AFEP) targeting the African-American population of the Mid-Carolina AAA.
- ✓ NC Senior Games continued to be a national leader and model Senior Olympic program, with 53 local games serving all 100 counties, a State finals that has grown to more than 3,000 participants, more than 100 Ambassadors to be spokespersons for year-round health promotion and fitness, and expanded opportunities for residents of long-term care facilities and adult day services programs through "Adaptive Senior Games."

Objectives (2007–2011)

6. SHIIP and the Medicare Partners State Level Coordinating Committee will support programs that address education and critical policies around Medicare, such as information/workforce counseling, increased enrollment in Medicare Part D and the related low-income subsidy program, and NCRx.
7. DAAS and other members of the Healthy Aging Coalition, an interagency partnership including and supported by IOA, will implement strategies for a coordinated and systemic healthy aging initiative to address issues related to physical activity; nutrition; immunization; and prevention, delay, and management of chronic disease in the population 60 and older.
8. DMA, AARP NC, DAAS, NC4A, and the State Dental Society will collaborate to expand dental care access for special needs populations that are 60 years and older.
9. DAAS, the Carolinas Center for Hospice and End of Life Care, and other key stakeholders will develop methods and interventions to encourage older adults to name a surrogate decision-maker for health care and to have a conversation with that person about preferences for care at the end of life; and will provide end-of-life care education for use by health and human services providers.
10. DAAS will support the work of DMH/DD/SAS and their regional Geriatric/Adult Mental Health Specialty Teams to address long-term care needs of older adults with mental illness and their successful integration and assimilation into the community.

6. SHIIP and the Medicare Partners State Level Coordinating Committee will support programs that address education and critical policies around Medicare, such as information/workforce counseling, increased enrollment in Medicare Part D and the related low-income subsidy program, and NCRx.

The Medicare Modernization Act of 2003 made significant changes to the Medicare program, in particular, adding prescription drug coverage through the Medicare Part D program. Before such coverage was available, 43 percent of Americans with Medicare lacked drug coverage all or part of each year. In 2003, their average annual out-of-pocket spending for prescription drugs was $999. Often the cost of prescription drugs is such a financial burden for seniors and disabled persons, especially those living on a fixed income, that they go without their drugs or skip doses. To use this much-needed benefit effectively, it is critical that beneficiaries have accurate information and assistance in choosing a drug plan, so they can make wise purchasing decisions. Errors result in higher cost to individuals, and they may affect the overall quality of health care. Well-informed consumers make better choices, so it is important to provide ways to inform and educate them.

The Seniors' Health Insurance Information Program (SHIIP) of the North Carolina Department of Insurance (NCDOI) serves as a lead agency to provide information, counseling, and assistance to the State's 1.3 million Medicare beneficiaries. SHIIP is coordinated in each county through an existing human service agency such as a council or department on aging, senior center, or Cooperative Extension. The Area Agencies on Aging also collaborate with SHIIP. Seniors, people with disabilities, and family caregivers are the most frequent SHIIP clients. SHIIP's services are provided by trained volunteer counselors (currently 880 of them) who work in the 110 county coordinating sites. SHIIP also operates a statewide toll-free line, staffed in Raleigh Monday through Friday from 8:00 a.m. until 5:00 p.m.

The national Centers for Medicare and Medicaid Services (CMS) selected SHIIP to play a key

role in North Carolina's educational campaign to help consumers understand Medicare Part D benefits and the Medicare Part D Low Income Subsidy Program. Currently, 92 percent of North Carolina's Medicare beneficiaries have prescription drug coverage. Efforts will continue to identify people who do not have coverage or would be eligible for extra help through the Low-income Subsidy Program or the State's NCRx program, a program introduced by the State in 2006 to help seniors with low income cope with the cost of Medicare prescription drug premiums. In order to qualify for NCRx, seniors must be 65 or older and must meet certain requirements based on income and assets.

The Medicare Partners State Level Coordinating Committee (MPSLCC) plays a critical role in providing support and guidance on policies affecting Medicare/Medicaid recipients in North Carolina. The committee is composed of public and private entities that have a special interest in ensuring that as many North Carolinians as possible enroll in a Part D plan and that those with low incomes sign up for the subsidy program or extra help through the State. SHIIP and the MPSLCC will continue to develop strategies for educating and assisting citizens and service providers about Medicare and Medicaid benefits.

7. DAAS and other members of the Healthy Aging Coalition, an interagency partnership including and supported by IOA, will implement strategies for a coordinated and systemic healthy aging initiative to address issues related to physical activity; nutrition; immunization; and prevention, delay, and management of chronic disease in the population 60 and older.

In the past few years, significant collaboration among universities and public health and public policy organizations has produced considerable momentum for an evidence-based approach to health promotion and chronic disease management. Federal organizations such as the Centers for Disease Control and Prevention and AoA are identifying ways to develop programs grounded in research into the benefits, harms, and costs of interventions, to increase the ones proven to be effective, efficient, and feasible.

"Promoting health and wellness through programs like 'Eat Smart, Move More' as well as initiatives to manage chronic diseases are vital to the well-being of our senior population."

Rev. Lamar Moore, Speaker
Senior Tar Heel Legislature (STHL)

A 2004 report released by the Merck Institute on Aging and Health entitled *The State of Aging and Health in America* notes that North Carolina does not meet national standards for older adults in oral health, proper nutrition, and physical activity levels. The State is ranked 42nd or worse in the percent of older adults who are disabled, obese, or report physically unhealthy days. The State Data Center indicates that 45.7 percent of North Carolinians age 65 and over have a disability. Chronic diseases, many of them preventable through healthier lifestyles, are responsible for 65 percent of all deaths in the State.

Changes in organizational infrastructure have resulted in increased joint or collaborative programs between the DPH and other divisions of State government, as well as other public and private partnerships. The development of a sustainable collaboration between DPH and DAAS will insure a coordinated and systemic effort to address healthy aging in North Carolina. The strengths and expertise of each division will result in improved coordination of efforts to address health issues for older adults and will maximize resources. These two divisions have previously collaborated on several successful projects. The working relationships between these two agencies are being formalized in a memorandum of agreement to insure sustainability for future endeavors. Emerging national initiatives with new funding sources have brightened the prospect for collaboration to develop a more coordinated and systemic effort to address healthy aging. Part of the impetus for this comes from Medicare Part D's emphasis on prevention—*My Health. My Medicare.*

Keeping in mind some of these statistics, the coalition has identified the following strategies to improve health promotion and chronic disease management in the State:

- By 2008, form a healthy aging team from among divisions of State government to develop jointly a Healthy Aging Roadmap that outlines a more coordinated and systemic effort to address healthy aging in the State.
- By 2011, increase the percentage of adults 65 and older who are vaccinated annually against influenza and pneumococcal disease.
- By 2011, implement the Chronic Disease Self-Management Program, which targets minority and/or rural older adults with low income in three geographic regions.
- By 2011, develop public and private partnerships both at the State and local levels to promote proper and adequate nutrition through nutrition programs serving older adults.
- By 2011, implement the Active Options project, a web-based Census and searchable database of community physical activity programs for older adults, in all NC counties.

8. DMA, AARP NC, DAAS, NC4A, and the State Dental Society will collaborate to expand dental care access for special needs populations that are 60 years and older.

Few states have Medicaid dental programs that provide a package of services for adults as comprehensive as North Carolina's. However, it is vital that the State continue to cover more than just emergency treatment for adult patients to maintain their oral health. This would include particular attention to the older special needs population that relies heavily on Medicaid to pay dental care bills. Although the mechanism is not clear, studies have demonstrated a link between poor oral health and both cardiovascular disease and stroke in older adults. Decayed or missing teeth or ill-fitting dentures may keep adults from maintaining a healthful diet. Either of these outcomes of poor oral health may result in more expensive care for the individual.

As of October 2006, there were four nonprofit mobile dental care units serving North Carolina's special care population in the Charlotte and Greensboro areas (two units in each). The mobile units provide special dental care services to frail elders and developmentally disabled populations. In a presentation to the 2006 NC Study Commission on Aging, the dental care model was presented as an effective way to: accept special needs patient referrals from local providers; serve the rapid influx of retirees in North Carolina; relieve the gap in service from the deinstitutionalization of the mental health hospital system; and support special care patients, families, local providers, and organizations representing special needs patients. The clinics have three sources of

revenue: private pay patients (approximately 20 percent of patients seen), Medicaid patients (approximately 80 percent of patients seen); and a retainer fee, which is required for the nonprofit units to break even. The providers report that there is a statewide waiting list for those wanting on-site dental services, yet there are currently only two areas of the State in which these services are available.

Many of the services most needed by adults are among the most poorly reimbursed procedures in the NC Medicaid Dental Program. An increase in reimbursement rates for these procedures would likely attract more dental providers who will treat these clients. DMA has used State appropriations to raise the reimbursement rate for many procedures that adult patients most commonly need. The rates were increased in May 2006 (retroactive to October 1, 2005) to correspond to a market-based benchmark, the National Dental Advisory Service median for each dental procedure. It will continue to be important to examine reimbursement rates for these procedures relative to the cost to providers of treatment.

In addition, steps will be taken to study the merits of adding a reimbursable procedure code recognized by the American Dental Association that captures the extra effort and time commitment providers must make to treat special needs patients—something that might be considered across a broader spectrum of health care delivery disciplines. Reimbursing extra effort for treating clients whose behaviors or complicated case histories require extra time and management may increase the number of providers willing to treat these clients.

Another strategy that may produce a great change is improved outreach efforts to educate caregivers—family as well as paid staff—about the dental benefits available under the NC Medicaid Dental Program and to recognize oral health problems. Too often caregivers do not realize that many dental procedures are covered for special needs patients. Thus, improving access may rely on educating caregivers. The partnership among DMA, AARP NC, DAAS, NC4A, and the State Dental Society can be extremely helpful in spreading the word among families and the various institutional long-term care settings about the availability of services to Medicaid recipients.

9. DAAS, the Carolinas Center for Hospice and End of Life Care, and other key stakeholders will develop methods and interventions to encourage older adults to name a surrogate decision-maker for health care and to have a conversation with that person about preferences for care at the end of life; and will provide end-of-life care education for use by health and human services providers.

An indispensable component of healthy aging and engaging with life is to make decisions about one's care at the end of life. The end-of-life care continuum includes palliative and hospice care, advance care planning, and support for bereavement. The NC End of Life Care Advisory Council (NCEOLCC, formerly the NC End of Life Care Coalition) is housed in The Carolinas Center for Hospice and End of Life Care. Formed in 1999 to promote quality end-of-life care services, the NCEOLCC includes representatives of 34 state stakeholder organizations and works closely with more than 30 community coalitions to promote high quality end-of-life care and encourage completion of advance directives.

In 2003 NCEOLCC collaborated with AARP NC to survey 3,586 of its members regarding end-of-life care. Respondents expressed strong preferences: almost 90 percent said that total physical dependency would be worse than death, and around three-quarters were worried about not being able to communicate wishes, living in great pain, and being a burden to their family. Some 79 percent of White respondents and 66 percent of African Americans expressed concerns about using life support, but only 50 percent of Whites and 30 percent of African

Americans had advance directives. Clearly, there is a great need to encourage people of all ages, and older adults particularly, to make known their preferences for care at the end of life through advance directives.

To prepare advance directives, however, adults need opportunities to learn about care options at the end of life, how to declare their wishes using the NC Advance Directive Registry, how to appoint a surrogate decision maker, as well as about organ and tissue donation. Family members are encouraged to be included in this process. Currently, an active caregiver network exists statewide to help prepare family caregivers to participate in this important discussion.

Education in the community is one strategy for accomplishing this objective. A second strategy is to increase the competence and experience of human services and health care providers in holding compassionate conversations with older adults and their loved ones about end-of-life care. Physicians and other providers have an important role in facilitating thoughtful discussions about advance directives during initial consultations and assessments, periodic contacts and examinations, in hospitals at admission and at transfers from one health care setting to another, as well as when clients receive a diagnosis of a chronic illness or have a prognosis of one year or less of life remaining.

There is a great need to encourage people of all ages, and older adults particularly, to make known their preferences for care at the end of life through advance directives.

10. DAAS will support the work of DMH/DD/SAS and their regional Geriatric/Adult Mental Health Specialty Teams to address long-term care needs of older adults with mental illness and their successful integration and assimilation into the community.

To reduce unnecessary admissions of older adults to State psychiatric hospitals and help those who are able to return to the community, the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) currently funds 20 community-based geriatric/adult mental health specialty teams, 7 of which serve multiple communities.

The purpose of the teams is to increase the capacity of long-term care facilities and service providers to address mental health issues by providing training and consultation to caregivers, including the staff of adult care homes, nursing facilities, and other professionals and/or family members taking care of older adults; linking older adults with needed mental health treatment services and with assistance from the aging service network; and helping with discharge planning for older adults returning to the community from State psychiatric hospitals.

At a minimum, each team is composed of a registered nurse and a master's-level mental health clinician with geriatric expertise. Some teams that cover large areas have additional staff members. The teams provide most services where individuals live, rather than in the office or clinic setting.

There are multiple opportunities for collaboration between DMH/DD/SAS and DAAS, both at the State level and also at the regional level, to help older adults live safely in the community for as long as possible, receive appropriate treatment in long-term care facilities, and prevent entry into mental health institutions if care in the community or at home can be arranged.

Economic Security

Economic security allows individuals greater choices for independent living and productive aging while reducing a major source of stress for older adults. When older adults retire, their sources of income and spending priorities often change dramatically. Seniors with middle and lower incomes may be challenged to use their resources to best advantage, to find ways to supplement their income with continued employment, and to buffer themselves against unexpected expenses for health care and long-term care. There are a variety of public benefit and service programs available that can ease some of the strain, but some are underfunded and others are underused because their intended beneficiaries do not know they exist. Objectives in this area reflect a variety of approaches to improve the financial well-being of older North Carolinians.

Major Accomplishments (2003–2007)

- ✓ The NC Health and Wellness Trust Fund created NCRx, a state prescription drug assistance plan, to help seniors with low income afford to participate in the federal Medicare Part D prescription program.
- ✓ The DMA implemented an Adult Medicaid Mail-in Application to help persons and their caregivers in their initial pursuit of benefits.
- ✓ DAAS's Older Worker Program has begun establishing memoranda of agreement with local Workforce Development Boards statewide to increase referrals and possible employment of older workers.
- ✓ The NC Assistive Technology Program (NCATP) within DVR is increasing older persons with disabilities' use of technology to aid them in maintaining employment and improved functioning in the workplace.
- ✓ Communities in several regions of the State have started efforts to identify and recognize senior-friendly businesses.

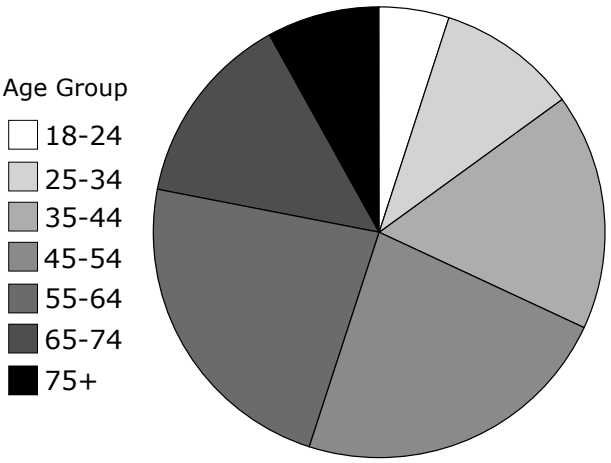
Objectives (2007–2011)

11. DAAS will work with AARP NC, NC Cooperative Extension, business leaders, working family caregivers, and other stakeholders to promote caregiver-supportive policies within the workplace and to explore State legislative options to support working caregivers.
12. DAAS will develop, in collaboration with the workforce delivery system, IOA, and AARP NC, a public awareness initiative that will strengthen the partnership of informing older workers of issues affecting them and to increase the visibility of older workers as a valuable resource in the workforce.
13. DAAS will work with NCDOI, DMA, DMH/DD/SAS, NC4A, and other key stakeholders to participate in the federal "Own Your Future" Long-Term Care Awareness Campaign to inform the public about long-term care planning including long-term care insurance and other financing options.
14. DMA will lead in developing a Long-Term Care Partnership Program to reduce future Medicaid costs for long-term care.
15. DAAS will continue to work with DSS and NC4A to implement strategies to address outreach and access issues relating to the use of the Food Stamp Program by older North Carolinians.

11. DAAS will work with AARP NC, NC Cooperative Extension, business leaders, working family caregivers, and other stakeholders to promote caregiver-supportive policies within the workplace and to explore State legislative options to support working caregivers.

There are over 1.2 million family caregivers in NC. National studies estimate that two-thirds of these family caregivers are employed either full- or part-time, and nearly half of all caregivers in North Carolina are ages 45 to 64, peak years for responsibility, salary, and advancement in their careers.

Chart 1. Adult Caregivers in North Carolina by Age



2005 Behavior Risk Factor Surveillence System (BRFSS)

Some studies estimate that as many as 15 percent of American workers provide regular care for an older adult. AARP NC's Caregiving in the Workplace Survey elicited responses from over 550 NC companies in 80 counties and more than 100 cities and towns. Almost two-thirds of these employers reported knowing that employees provided care to an older adult. Half said that employees had asked for time off for caregiving, while about one-third said employees had requested time off under the Family Medical Leave Act. Almost one-fifth said they offer no programs or services for caregivers. The biggest barrier to offering support programs was covering the employee's time. About two-thirds said caregiving has a noticeable effect on employees' performance, and almost three-quarters said they are interested in learning more about resources and supports available for caregiving employees.

While about one-fifth of the employers surveyed said they had no programs for caregivers, in contrast, half of employees participating in an internet AARP NC survey of several corporate and public organizations said their employer had no caregiver benefits, and 39 percent said they did not know if benefits were available.

Caregiving takes an economic toll on both the employee and the employer. A recent national survey of working caregivers found that 90 percent reported doing at least one of the following things because of their caregiving responsibilities: (1) arriving late, leaving early, or taking time off; (2) taking a leave of absence; (3) reducing work hours; (4) giving up work entirely; (5) losing benefits; (6) turning down promotions; or (7) retiring early.

Employees often take time off or use work time to attend to routine caregiving tasks such as health care appointments, legal matters, housekeeping and home maintenance, personal care, and safety issues. Emergencies make it hard to plan absences, and caregivers who are distracted, stressed, and worried about their family members may not pay sufficient attention to their work. Caregiving costs US businesses about $2,110 annually per full-time caregiving employee, amounting (conservatively) to between $17 billion and $33.6 billion. However, employers can relieve some of the stress on employees and possibly improve performance by allowing flexible job schedules and providing services ranging from care management support to on-site adult day services.

Many North Carolina companies have already made great strides in supporting caregivers at work, not only because they recognize the effect on their bottom line, but because they

believe it is the right way to treat their employees. To retain a mature, productive workforce, the partners working toward this objective aim to identify and multiply these corporate success stories, regardless of the size of the organization, and this, in turn, will promote increased economic security for the State and its citizens.

12. DAAS will develop, in collaboration with the workforce delivery system, IOA, and AARP NC, a public awareness initiative that will strengthen the partnership of informing older workers of issues affecting them and to increase the visibility of older workers as a valuable resource in the workforce.

The Workforce Development System is a partnership between North Carolina's Department of Commerce, Employment Security Commission, Community College System, and DHHS. Each of these agencies cooperates to build, maintain, and improve this system, also known as the JobLink System, under the Workforce Investment Act of 1998.

Some employers already recognize the value older workers bring to the workplace–responsibility, stability, dedication, experience, productivity, and mentoring.

The JobLink System was established to provide improved performance, more coordinated access to services, and accountability. Its guiding vision is that all customers will be served through a seamless delivery system characterized by effective technology; well-trained, customer-focused personnel; and conveniently located access points around the State.

13. DAAS will work with NCDOI, DMA, DMH/DD/SAS, NC4A, and other key stakeholders to participate in the federal "Own Your Future" Long-Term Care Awareness Campaign to inform the public about long-term care planning including long-term care insurance and other financing options.

Many people do not think about their future long-term care needs and, therefore, fail to plan appropriately. Because Medicare does not pay for long-term care, either in the community or in facilities, families and individuals can face considerable expenses they may find hard to meet. In 2005, the annual cost of assisted living in Raleigh and Charlotte was $34,000 to $39,000, respectively, and for nursing home care, $55,000 to $71,000. When individuals become impoverished, Medicaid provides support, but this shifts the cost of care to taxpayers. It is important, both for the financial well-being of families and the State, that individuals and families become more aware of the potential need for long-term care, whether at home or in a facility, identify their preferences, and plan how to accommodate them.

North Carolina has already taken steps to educate the public, including aging boomers, about the importance of planning for their long-term care needs. In 1999, the NC Institute of Medicine convened the Task Force on Long Term Care to examine the issues and to develop a plan for North Carolina. In 2001, the task force published *A Long Term Care Plan for North Carolina: Final Report*, which included 47 recommendations for developing a long-term care system. One of the recommendations included developing outreach efforts to publicize the benefits of purchasing long-term care insurance.

In response to this recommendation, DAAS partnered with NCDOI, SHIIP, and AARP NC to develop an awareness campaign entitled "It's about You, Your Children and Your Parents." A brochure was developed and disseminated, and presentations were made to groups in the public and private sectors throughout the State. In 2004, DAAS collaborated with SHIIP on CMS's long-term care initiative. Two-day workshops were conducted in four locations across the State to prepare a core group of trained SHIIP volunteers to assist consumers with questions about long-term care planning.

In 2005, the US Department of Health and Human Services initiated the "Own Your Future" campaign as a partnership between the federal government and states to offer information to consumers about how to plan for long-term care. In 2007, DAAS hopes to join NCDOI, AARP NC, DMH/DD/SAS, DMA, and other key stakeholders to implement the "Own Your Future" campaign here. Nationally, this direct mail campaign has been supported by each participating state's governor and aimed at households with members between ages 45 and 70, who are encouraged to order a long-term care planning kit with information about planning resources and information services in the State.

14. DMA will lead in developing a Long-Term Care Partnership Program to reduce future Medicaid costs for long-term care.

The 2006 Session of the NC General Assembly directed DHHS to develop a program to reduce future Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid. DMA is taking the lead in the development of this program with participation from other stakeholders.

Under the Deficit Reduction Act of 2005, states can submit a plan amendment to CMS to request exemption from estate recovery in an amount equal to the benefits paid by certain long-term care insurance policies, if those benefits were disregarded in determining an individual's Medicaid eligibility. Policies must meet specific conditions, and the State insurance commissioner must certify that the policy meets those conditions.

DMA is meeting with key stakeholders, such as DAAS, NCDOI, the Attorney General's Office, the Elder Law Section of the NC Bar, and others in early 2007 to prepare a State Medicaid Plan amendment for review by appropriate General Assembly committees before June 30, 2007, so it can be submitted in the third quarter of the calendar year.

15. DAAS will continue to work with DSS and NC4A to implement strategies to address outreach and access issues relating to the use of the Food Stamp Program by older North Carolinians.

The Food Stamp Program is a federal program that helps provide food assistance to families with low incomes. In North Carolina monthly allotments of food stamp benefits are issued via Electronic Benefit Transfer cards (EBT cards). The purpose of the Food Stamp Program is to end hunger and improve nutrition and health. It helps eligible households with low incomes buy the food they need for a nutritionally adequate diet.

Older adults have historically underutilized the Food Stamp Program. Nationally, only 30 to 40 percent of eligible older people are enrolled in the program, while eligible women and children have a 70 to 80 percent program utilization rate. Through extensive research, the US Department of Agriculture (USDA) has determined that older adults do not apply for or enroll in the Food Stamp Program owing to a lack of information; assumptions that the program is only for families with young children;

anticipated low benefits; complex, difficult, and confusing application procedures; and such psychological reasons as stigma related to applying for and using benefits.

According to USDA studies, the most commonly mentioned barrier to participation is pride. Other reported barriers include difficulty understanding eligibility rules, lack of transportation, and low benefit levels. In SFY 2002–04, DAAS in cooperation with DSS conducted a cost-effective research project to improve outreach and access to the Food Stamp Program for eligible older adults living in south central North Carolina. Different approaches were tested in different counties to address known barriers to food stamp participation among older adults with low incomes.

The evaluation found that program participation increased when brochures, presentations, screening, and application assistance was provided. Further positive outcomes occurred when outreach workers helped the applicant go through the process by interpreting questions and obtaining information and documentation needed to complete the form.

In NC only 29.8% of eligible individuals 65 and older received food stamps in February 2006.

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Technology

Aging boomers and current older adults
are becoming increasingly able to use new technologies
to enhance their lives and maintain their independence.
The next four years will see even more
improvements in the way technology can be used:
through assistive and
adaptive devices to help individuals
manage and compensate
for disabilities and to streamline access
to services through readily accessible
information about services,
self-assessment tools
to help people identify
the support they need, and
shared Web-based tools
for assessment and planning
for service provision
from different organizations.

Major Accomplishments (2003–2007)

- ✓ DHHS initiated NC care LINK, a statewide web-based community resources database to assist consumers and service professionals with information and assistance.
- ✓ DAAS has substantially revised the client registration data it collects for HCCBG and the Family Caregiver Support Program to aid program management, planning, and evaluation, and is converting its Aging Resource Management System (ARMS) for web-based use by participating service providers.
- ✓ Through its expanded services and increased outreach, DVR is showing a steady increase in use of its Assistive Technology Program by older adults.
- ✓ Supported by the Blue Cross and Blue Shield of NC Foundation and others, several regions (e.g., the Cape Fear Council of Governments) have acted to improve disaster preparedness for vulnerable populations that includes use of computer applications to develop registries and map populations.
- ✓ DFS established a website with information about adult care homes including imposed penalties and fines (http://facility-services.state.nc.us/adultcarehomefines.html).
- ✓ UNC's Developmental Disabilities Training Institute (DDTI), with a workgroup of diverse stakeholders, developed videotapes and accompanying materials to educate individuals and families considering guardianship for incapacitated adults.
- ✓ DSDHH expanded the Telecommunications Equipment Distribution Program to provide consumers use of one hearing aid with a telecoil device for better communication in use of the telephone.

Objectives (2007–2011)

16. DAAS, in collaboration with the North Carolina Assistive Technology Program and DVR, will initiate a pilot program with at least one local community/organization to increase the availability of assistive technology in underserved and rural areas.
17. DAAS will collaborate with DSDHH and DSB to educate seniors and their caregivers about hearing and vision loss and the accessibility and availability of assistive/adaptive devices for people who are deaf and hard of hearing and for those with vision impairments and to assure that seniors and their caregivers receive training and services to assist them in effectively incorporating these devices into their lives.
18. DAAS will collaborate with DSDHH, DSB, and DVR to develop and disseminate materials such as brochures, drop-in articles, and fliers that identify hearing and vision loss concerns and assistive technology funding resources available to seniors in North Carolina.
19. OCS, DIRM, NC4A, and DAAS will collaborate to fully implement NC care LINK, a statewide web portal for information about community resources.
20. DMA, in partnership with DAAS and others, will implement a fully automated, uniform screening and assessment process for all long-term services that are Medicaid-funded and explore use with non–Medicaid-funded services.

16. DAAS, in collaboration with the North Carolina Assistive Technology Program and DVR, will initiate a pilot program with at least one local community/organization to increase the availability of assistive technology in underserved and rural areas.

Assistive technology is any device that makes everyday life easier and increases independence. Identifying clothing and dressing, cooking safely, eating, answering the phone, hearing the doorbell or smoke alarm, reading the paper, and identifying and managing medications are daily activities that most adults do without a thought. Some of these tasks, however, can become difficult for those who have or are developing physical and/or sensory limitations.

As adults age, they look for easier, safer, and quicker ways to perform daily tasks independently, and assistive technology devices provide new options. These devices increase the possibility that adults with disabilities can continue to live in their own home and be involved in their community.

Assistive technology includes both low-tech and high-tech devices: a built-up handle for a spoon, a door pull, elastic shoelaces, or a medical alert system bracelet. Many assistive technology devices can be purchased "off the shelf" and are ready for immediate use. However, older adults are often overwhelmed by the variety of items that are available and uncertain which would meet their individual needs. They also may have only a short-term need for a particular device or insufficient funds to pay for it.

One strategy for helping adults with disabilities identify and use appropriate assistive devices might be the establishment and/or expansion of community-based "loan closets," which would provide people with the opportunity to use devices for short periods of time as the need arises or to try out equipment to make sure it works for them before buying it. There are good examples of this approach upon which NC can build.

"What if the senior citizen experiences both hearing loss and vision loss and yet his/her behavior seems more indicative of dementia when it really is the dual disability impeding effective communication? This could result in loss of self-determination for the senior citizen."

Jan Withers
Director, DSDHH

17. DAAS will collaborate with DSDHH and DSB to educate seniors and their caregivers about hearing and vision loss and the accessibility and availability of assistive/adaptive devices for people who are deaf and hard of hearing and for those with vision impairments and to assure that seniors and their caregivers receive training and services to assist them in effectively incorporating these devices into their lives.

The use of adaptive devices and assistive technology greatly enhances the independence of people with auditory and visual impairments. It will be important in the next years to encourage older adults to seek out assistive devices and to make acquiring and learning how to use them easier, as boomers age into the years when they are most likely to develop adult-onset hearing and vision loss.

Projections from DSDHH indicate that by the year 2030, approximately 20 percent of North Carolinians will be diagnosed with some form of hearing loss, and service data show that more than half of DSDHH customers are 65 or older. In SFY 2005–06, the number of DSDHH clients in that age group jumped 164 percent (321 percent for those seeking hearing aids).

People who experience adult-onset hearing loss wait an average of seven years before seeking any help. Older adults generally require more time to learn how to use adaptive technologies that compensate for hearing deficits—hearing aids in particular. A study done by the National Council on Aging (*Hearing Health,* January/February 2000) debunks the myth that untreated hearing loss in older people is a harmless condition. It found that coping with the daily stress caused by hearing loss is exhausting, physically as well as mentally. Misunderstanding of oral communications causes significant problems among family members. Compared to peers who use hearing aids, older people with hearing loss but no aids are more likely to report sadness, depression, worry, anxiety, paranoia, emotional turmoil,

insecurity, and reduced participation in social activity. Older people whose hearing loss has been treated often report better relationships with family, more positive feelings about themselves, improved mental health, and greater independence and security.

The 2000 Census reported that there were 87,109 people in North Carolina with blindness or vision impairment after correction. As has been mentioned elsewhere, growth in the proportion of seniors greatly outstrips growth of North Carolina's population generally. In SFY 2005–06, 74 percent of consumers served by the DSB's Independent Living Rehabilitation (ILR) program were 55 and older. As the population in North Carolina continues to grow and age, the number of people who have significant vision loss will increase.

For people with visual impairments, access to printed material and information is one of the most critical needs addressed with the use of assistive technology. Although the boomer generation is more accustomed to using technology than the current older generation, as they develop age-related vision loss, their demand for technology that assists them in gaining access to information will increase, as will their demand for training in using these technologies.

18. DAAS will collaborate with DSDHH, DSB, and DVR to develop and disseminate materials such as brochures, drop-in articles, and fliers that identify hearing and vision loss concerns and assistive technology funding resources available to seniors in North Carolina.

There are approximately 27,000 North Carolinians, the majority of whom are seniors, with both hearing and vision loss. DSDHH, DSB, and DVR offer a variety services to assist individuals in adjusting to hearing and/or vision loss and learning to live independently and safely in their home and community with their disability.

Unfortunately, the services provided by State government and local agencies are often confusing to older adults. They are not sure which agency to call and what questions to ask. Brochures, articles, and fliers that identify hearing loss concerns and assistive technology funding resources will be developed in an easy to read format. These materials will be circulated at senior centers, retirement homes and senior support groups. They will also be provided in alternative formats, such as large print. The goal of these materials will be to inform individuals about available services and resources and make accessing them less confusing.

As adults age,

they look for easier,

safer, and quicker ways

to perform daily tasks

independently,

and assistive

technology

devices provide

new options.

19. OCS, DIRM, NC4A, and DAAS will collaborate to fully implement NC care LINK, a statewide web portal for information about community resources.

The Office of Citizens Services (OCS), Division of Information Resource Management (DIRM), and DAAS, all in DHHS, have begun implementation of a web portal—NC care LINK—to provide information and referral (I&R) on all health and human services. Once it is put completely into service, consumers throughout the State will have access to on-line information that is essential to making informed decisions..

The same system will support local Aging and Disability Resource Connections (ADRCs) and other community professionals in assisting consumers to make personal choices about the services they need. Through NC care LINK, consumers will have 24-hour web-based access to resource directories and related tips and guidelines about statewide long-term care services and supports.

The initial implementation of NC care LINK is supported by DAAS's current ADRC grant and State funds. In December 2005, a vendor was selected to begin implementation, and the design will be piloted by spring 2007. Community resource information will be fed to the State web portal by around 20 data hubs. Once testing is completed, DHHS will work with local I&R services/human service agencies and designated ADRCs to promote the presence and use of NC care LINK throughout the State.

To make the most of this resource, DHHS will plan and design additional ways the content and tools in NC care LINK can support consumer choice. A decision-making tool will be included that will provide consumers with a step-by-step process to help them determine what support and services they need and guide them to resources in their community. This will empower them to make informed choices about their care with the assistance of family members and professionals.

20. DMA, in partnership with DAAS and others, will implement a fully automated, uniform screening and assessment process for all long-term services that are Medicaid-funded and explore use with non-Medicaid-funded services.

The Medicaid program funds multiple long-term care services in various settings. Currently each program has its own distinctive access and management processes, and this contributes to a fragmented system. There is no way to compare performance of programs across the continuum of care, and the various information technology (IT) systems now in place do not offer any form of access to consumers or support the decision making of human services professionals.

DMA, with support from Electronic Data Systems Corporation (EDS), is developing a web-based screening tool to assess medical function for eight Medicaid long-term care services. Using the tool across services will allow consumers to be informed of all the Medicaid services for which impaired physical or mental functioning makes them eligible (the system, however, will not determine financial eligibility), simplify access for recipients, create uniformity for providers, enhance accountability and productivity across services, and increase collaboration.

DMA will also automate the assessment tool for services. Rather than program-specific IT applications, services would have a common web platform(s) for such key functions as information and assistance (I&A), uniform Medicaid screening, case management, and even consumer self-management. Included in DMA's systems transformation work is adapting a web-based application, provisionally called NC Self-Care, designed to provide consumer self-management tools and self-direction supports to persons with long-term care/chronic care needs.

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Safety and Security

Safety and security at home, in the neighborhood, and on the street is a fundamental part of a livable and senior-friendly community. Among the areas to be addressed in the next four years are the five mentioned in this Plan*: helping communities prepare to care for vulnerable adults in times of disaster; reducing harm to adults with disabilities from abuse, neglect, and exploitation; assisting victims of consumer fraud; improving the skills of direct-care workers in long-term care settings; and making communities safer for adults with cognitive disabilities.*

Major Accomplishments (2003–2007)

- ✓ At the direction of the NC General Assembly, DAAS has developed a model to pilot for the Adult Care Home Quality Improvement Consultation Program.
- ✓ The NC General Assembly appropriated funds to add eight full-time Regional Long-Term Care Ombudsmen to make progress in meeting a national benchmark for promoting and protecting the rights of residents of nursing facilities and adult care homes.
- ✓ DAAS, working the NC Justice Academy and others, started S.A.F.E. (Strategic Alliances for Elders in Long Term Care), an initiative that has already led to the training of 80 law enforcement personnel about how best to investigate alleged crimes against residents of long-term care facilities.
- ✓ After conducting a statewide survey to assess community readiness, DAAS developed special medical needs disaster training modules and trained over 600 persons across the State on special medical needs planning and preparedness; funded by a US Homeland Security Grant, the NC Commission on Volunteerism and Community Services trained over 3,500 seniors on personal emergency preparedness.
- ✓ In 2006, the NC House Study Committee on State Guardianship Laws prepared a report of its findings and recommendations.
- ✓ DAAS finalized its work with the Adult Protective Services Task Force and offered to the 2006 Study Commission on Aging a recommended Adult Protective Services (APS) Clearinghouse Model that would substantially reform APS.
- ✓ A Medication Nurse Aide curriculum was developed for use within nursing homes, and an associated job category and registry were established.
- ✓ DAAS continued its leadership of the NC Senior Consumer Fraud Task Force, and working with the State Attorney General's Office, started a Victims Assistance Program to use the skills of trained senior volunteers to become mentors to older victims of fraud.
- ✓ A broad coalition of State agencies and organizations interested in senior driver safety became a working group of the NCDOT Executive Committee for Highway Safety in 2005 with a goal of recommending strategies for reducing crashes involving older drivers and pedestrians.
- ✓ DHHS secured grants to address the recruitment and retention of direct-care workers, including helping develop the statewide Direct Care Workers Association of North Carolina and working with the NC General Assembly to create NC NOVA (New Organizational Vision Award) as special licensure status for nursing homes, adult care homes, and home care agencies that voluntarily meet higher workplace standards.

Objectives (2007–2011)

21. DAAS and other partners will work with the proposed Governor's Council on Emergency Management for Persons with Disabilities and the Elderly to ensure that every county in NC develops and maintains a special needs medical registry and a comprehensive plan for community-based medically fragile individuals, if feasible.
22. In partnership with the NC Senior Consumer Fraud Task Force and NC4A, DAAS will increase awareness of consumer fraud by encouraging a more comprehensive dissemination of consumer fraud alerts to those seniors who are most at risk in each region and by implementing an effective Victims Assistance Program that reaches at least 50 North Carolina counties.
23. DHHS will continue to support new initiatives such as the NC New Organizational Vision Award and the Medication Aide Registry Program that address current shortages and growing demand for direct-care workers in long-term care settings as a result of the aging of the population.
24. Subject to funding from the NC General Assembly, DAAS will assist 20 county departments of social services in implementing the Adult Protective Services Clearinghouse Model.
25. DAAS, with key partners, will lead the initial research and assessment of existing programs designed to increase safety and security measures for those with Alzheimer's disease and other dementias with particular focus on preventive and responsive approaches to wandering.

21. DAAS and other partners will work with the proposed Governor's Council on Emergency Management for Persons with Disabilities and the Elderly to ensure that every county in NC develops and maintains a special needs medical registry and a comprehensive plan for community-based medically fragile individuals, if feasible.

Adults of all ages who have disabilities are especially vulnerable during disasters. Whether because of sensory, cognitive, or physical limitations, chronic conditions, or isolation, adults with disabilities may need more time and assistance to prepare for a disaster and help in recovering from it. While many resources already exist to assist them, access to these resources can be problematic because planning varies so much from community to community.

North Carolina General Statute 166A-7 places responsibility for local disaster plans and their deployment with city and county governments, and this leads to variability from county to county and even from city to city within a county. In addition, the statute itself does not clearly specify the elements of a disaster plan, something that could provide guidance to county and local governments.

According to a survey conducted by DAAS in 2004 to which 96 of North Carolina's 100 counties responded, approximately 24 counties had voluntary special medical needs registries, and approximately 40 counties had plans for sheltering medically vulnerable populations. The plans differed considerably in their comprehensiveness.

Knowing who the community-based people with special medical needs are and where they live is vital to providing them with timely warning and support before and after disasters. Having concrete plans that detail the special medical needs sheltering process is also critical, so that county personnel are clear on roles and responsibilities and understand what resources are available.

22. In partnership with the NC Senior Consumer Fraud Task Force and NC4A, DAAS will increase awareness of consumer fraud by encouraging a more comprehensive dissemination of consumer fraud alerts to those seniors who are most at risk in each region and by implementing an effective Victims Assistance Program that reaches at least 50 North Carolina counties.

A 1999 survey conducted by AARP found that consumers over 50 are disproportionately vulnerable to telemarketing fraud. Particularly for those who are retired and living on a fixed income, losing assets to fraud artists can have a devastating financial and psychological impact. DAAS and the NC Department of Justice (DOJ) have worked together for many years to fight consumer fraud aimed at older North Carolinians.

In 1998, DAAS joined forces with AARP NC and the State Attorney General's Office to establish the Senior Consumer Fraud Task Force, composed of representatives from federal, State, and local law enforcement, aging advocates, the aging network, State and local Better Business Bureaus, US postal inspectors, and crime prevention agencies. To enhance the safety of seniors, the Task Force will continue to support and expand its current achievements.

Led by DAAS and DOJ, the Task Force has already developed preventive programs to:

- identify consumer fraud and deceptive trade practices in North Carolina in order to enhance awareness and prevention
- educate older North Carolinians about fraud, how to avoid being victimized, and what to do if they are defrauded
- use volunteers as a resource for law enforcement in the fight against fraud
- link various agencies to provide updated information on fraud and deceptive practices occurring in the State that target seniors.

DAAS is also developing a brochure on fraud and how to prevent it, which will be made available to all regions/counties in the State and distributed through senior centers and other service providers, at SCAM Jams, and through religious congregations and civic organizations. DAAS and the State Attorney General's Office have also staffed a telemarketing fraud unit, the Consumer Protection Division of the NC Department of Justice, through a grant received from the Governor's Crime Control and Safety Office.

People who have been victimized by scammers are at great risk of being victimized again. In SFY 2005–06, DAAS and the Attorney General's Office developed a Victims Assistance Program that uses trained volunteers in the fight against fraud. Among their tasks is assessment of victims' level of functioning, development of a safety plan, identification of community and social supports, and referral to professionals when appropriate. Volunteers who have had criminal background checks receive intense training to help them become effective mentors and "buddies" to victims of fraud. Volunteers' active presence in the community will help with the early detection of signs and symptoms of fraud among vulnerable seniors.

23. DHHS will continue to support new initiatives such as the NC New Organizational Vision Award and the Medication Aide Registry Program that address current shortages and growing demand for direct-care workers in long-term care settings as a result of the aging of the population.

Direct-care workers are certified nursing assistants, personal care attendants, and other unlicensed paraprofessionals who provide 90 percent of the hands-on daily care for persons receiving formal long-term services and supports, whether at home or in a residential setting. An adequate, well trained, and stable direct-care workforce is important to quality

care. North Carolina is one of 11 states that tracks turnover data on direct-care staff working in one or more long-term care settings. In 2005, average annual turnover rates by setting were as follows: nursing facilities, 116 percent; adult care homes, 111 percent; and home care agencies, 46 percent. Like many states, North Carolina has been working collaboratively with diverse stakeholder groups to address known causes of turnover among the direct-care workforce, as well as to take steps to increase the overall supply of these essential caregivers.

Two programs recently developed illustrate the types of initiatives the State will support to address this workforce issue. The first, NC New Organizational Vision Award (NC NOVA), developed by a broad-based Partner Team, focuses on improving the recruitment and retention of direct-care workers and the quality of care they provide. The second, the Medication Aide Registry Program, focuses on improving the training and qualifications of direct-care workers, providing specialized training related to the administration of medications.

Effective January 1, 2007, the NC NOVA program offers a special State license to home care agencies, adult care homes, and nursing facilities that voluntarily meet higher standards to support their workers on the job by providing opportunities for personal and professional growth and creating a team environment to deliver better care. This focus on an improved workplace environment is designed to help facilities develop and retain a stable, satisfied, and well-trained workforce, leading to greater satisfaction among residents, clients, and their families.

The Medication Aide Registry Program for long-term care facilities, implemented in November 2006, is the product of a four-year effort by DHHS, the NC Board of Nursing, and other stakeholders to develop (1) statewide uniform standards for nonlicensed direct-care workers who administer medications, (2) training materials and standards for trainers for the medication aide registry examination, and (3) requirements for employers of employees with this certification. Apart from addressing concerns about the safety of residents of long-term care and enabling facilities to use direct care and nursing staff more efficiently, establishing this qualification will add a rung to the job ladder for direct-care workers who are already qualified as nurse aides and to assist in retaining them.

In 2005, average annual turnover rates

for direct-care staff by setting were as follows:

nursing facilities – 116%

adult care homes – 111%

home care agencies – 46%

24. Subject to funding from the NC General Assembly, DAAS will assist 20 county departments of social services in implementing the Adult Protective Services Clearinghouse Model.

The State statute (NCGS Article 6, 108A) that governs adult protective services (APS) in North Carolina includes not only adults over 60 but younger adults (over 18) who have a physical or mental limitation that impairs their ability to protect themselves. DAAS will ensure North Carolina's APS program is strengthened and prepared to respond not only to the aging of the State's population, but to the increased emphasis on community-based treatment for adults with chronic mental illness, mental retardation, and substance abuse, which will likely increase the number of vulnerable adults who may become victims of abuse, neglect, or exploitation.

While many older adults will never need intervention to protect them, advancing age can produce physical and mental changes and illnesses that make older adults less able to protect themselves. Such changes, coupled with ageism in our society, can decrease older people's feelings of self-determination and personal power, potentially putting them at risk of mistreatment. Older adults who are isolated from friends and relatives are at greater risk, especially of self-neglect. Family stress arising from caregiving in isolation can also heighten risk.

Maltreatment of older adults often goes unreported. A national study conducted in 1996 found that only 16 percent of older adults who reported maltreatment had contact with their local department of social services, which usually receives and evaluates reports of abuse. Family and community members, rather than medical personnel, are the most common source of reports, so increasing awareness of what constitutes abuse, neglect, or exploitation, as well as what happens when a report is made may increase the proportion of instances reported and so increase the safety of disabled adults generally.

The APS Clearinghouse Model is a new and more comprehensive system of protection for adults who are abused, neglected, or exploited or who are at substantial risk. This model changes the emphasis of APS to a multifaceted array of protective services rather than merely a problem-solving, symptom-based intervention. Through this model, which embraces the basic tenets of APS—respect for all adults' freedom, dignity, and autonomy, and emphasis on least restrictive alternatives for those who need supportive care—county departments of social services would offer information and referral, outreach, or intervention to vulnerable adults of all ages who have been victims of abuse, neglect, or exploitation or who are risk of becoming victims.

The APS Clearinghouse Model embraces respect for all adults' freedom, dignity, autonomy, and emphasis on least restrictive alternatives for those who need supportive care.

As many as 70% of the more than 150,000 older North Carolinians with Alzheimer's disease or other dementias will wander away from where they live.

25. DAAS, with key partners, will lead the initial research and assessment of existing programs designed to increase safety and security measures for those with Alzheimer's disease and other dementias with particular focus on preventive and responsive approaches to wandering.

Over 150,000 older adults in North Carolina now have Alzheimer's disease or other dementias, and by 2025, this number will increase to over 250,000. As symptoms of the disease become more pronounced, as many as 70 percent of people who have Alzheimer's or another dementia will wander away from where they are living at least once. Whether they live in the community with a caregiver or in an institution, wanderers are at great risk, because they no longer recognize dangerous or threatening circumstances. If they are not found within 24 hours, up to half may die.

DAAS will assess the State's level of emergency preparedness regarding the safety of people with Alzheimer's and other dementias, with particular attention to wandering behavior. DAAS will also identify best practice models from other states for prevention and response and offer recommendations for changes in programs or policies that could improve the safety of people with dementia to appropriate entities (e.g., Department of Crime Control and Public Safety, Center for Missing Persons, Emergency Preparedness, Study Commission on Aging), as well as other State organizations that provide input to law enforcement officials and emergency response personnel.

These are some of the strategies that may increase the safety of this vulnerable population:

- develop a special emergency alert system (similar to the Amber Alert) for missing persons with dementia or other debilitating mental illnesses
- provide training for law enforcement officers, first responders, and other public safety officials about dementia
- promote enrollment of people with dementia in the Alzheimer's Association's Safe Return Program, whether they live in the community or in a long-term care facility
- institute search-and-rescue tracking programs such as Project Lifesaver for special needs populations.

Social and Cultural Opportunity

A livable and senior-friendly community
provides opportunities for all its citizens
to engage in a variety
of social and cultural activities.
Whether older adults use these opportunities
for personal growth,
to engage with others,
or to give back to their communities,
such opportunities are critical to successful aging.
Older North Carolinians represent
a largely untapped reservoir
of experience that can inform and delight
all age groups.
The five objectives outlined here are among
the many ways our communities can enrich
the lives of older adults and
be enriched by them.

Major Accomplishments (2003–2007)

- ✓ DAAS continued efforts to strengthen senior centers as effective community focal points for information, assistance, and civic engagement through its voluntary certification of Senior Centers of Merit and Excellence, its offering of the Ann Johnson Institute for Senior Center Management, and its support of the new Senior Center Alliance as part of the NC Association on Aging.
- ✓ The UNC Institute on Aging strengthened the Senior Leadership Enhancement Initiative to build a corps of senior leaders who can help the State and communities address issues affecting older adults and their families.
- ✓ DAAS initiated the Resident Companion Volunteer Visitation Program on a pilot basis to test its value for enhancing the quality of life for residents of long-term care facilities.
- ✓ Through the efforts of the Alzheimer's Association chapters, DAAS, and others, more than 100 Candlelight Reflections events were held statewide in November 2006 to recognize and honor family caregivers of persons with Alzheimer's disease and other debilitating conditions.
- ✓ DAAS, DSDHH, and DSB have increased communications and collaboration to cross-train workers to strengthen their networks' collective capacity for serving aging individuals who are deaf, blind, and hearing or visually impaired.
- ✓ DAAS and the AAAs developed a "train-the-trainer" model to assist persons working with caregiving families to become more aware of and prepared to respond to cultural diversity.

Objectives (2007-2011)

26. DAAS will use the experience of the Mid-Carolina Area Agency on Aging and others to work with IOA, and the Department of Cultural Resources to develop a model for libraries in a maturing society that promotes opportunities for life enrichment and learning for older adults.
27. The Benefits Navigator Program will have 450 trained public benefits volunteer counselors in all 100 counties, serving both older adults and younger persons with disabilities.
28. DAAS, in consultation with the Center for Aging and Diversity within IOA, will study the prevalence and location of older minorities, including the non-English-speaking populations, to assess the need for outreach and to design strategies that support the inclusion of these populations in activities and programs for older adults and their family caregivers.
29. DAAS will collaborate with the NC Senior Games and NC4A to publicize and strengthen senior participation in artistic endeavors through SilverArts, which emphasizes many areas of creative expression including heritage arts, literary arts, performing arts, visual arts, and cheerleading.
30. DAAS will work with senior center directors across the State and NC4A to increase the number of Senior Centers of Merit and/or Excellence.

26. DAAS will use the experience of the Mid-Carolina Area Agency on Aging and others to work with IOA and the Department of Cultural Resources to develop a model for libraries in a maturing society that promotes opportunities for life enrichment and learning for older adults.

The Americans for Libraries Council has an initiative called Lifelong Access Libraries. Through a fellowship program and annual institute, this initiative aims to develop a cadre of professional librarians who can "transform libraries into centers of lifelong learning and civic engagement for active older adults." The initiative is giving a new focus on aging and the development of partnerships between libraries and the aging network, and it provides a new avenue for community service for aging boomers.

North Carolina will use this model to develop partnerships among senior centers and other aging network organizations, existing lifelong learning centers, and local library systems to enrich lifelong learning for older adults, according to the needs of the community.

According to the Americans for Libraries Council, Lifelong Access Libraries will offer advisory councils for the purpose of planning and program development; learning activities for career opportunities; meeting spaces and educational programs that promote social and intergenerational interaction; programs that will assist in planning for the future; opportunities for community service; and educational programs targeted towards computer training, health, fitness, and information gathering.

27. The Benefits Navigator Program will have 450 trained public benefits volunteer counselors in all 100 counties, serving both older adults and younger persons with disabilities.

Benefits Navigator was established in 1995 as the Seniors Plus Program to develop a corps of trained volunteers who would be able to provide older adults with information and counseling on a large array of benefits (excluding Medicare, which is provided by SHIIP). In 2005 DAAS expanded the target population of Seniors Plus to include persons with disabilities as part of the ADRC initiative. The program was renamed Benefits Navigator to reflect its broadened scope.

Many older North Carolinians will likely be among the volunteer Benefits Navigators in their communities. Benefits Navigator provides a meaningful volunteer experience for older adults by providing one-on-one counseling opportunities. This important benefits counseling helps North Carolina citizens access public benefits they might need for economic security and well-being. Volunteers are required to participate in intensive two-day training on Medicaid, Social Security, Food Stamps, the Low Income Energy Assistance Program, among other benefits. Trained Benefits Navigators receive annual updates and turn in counseling reports regularly to DAAS.

To date, the program has over 300 volunteer Benefits Navigators in 65 counties, who provide counseling and assistance on public benefits. Over the next four years, DAAS will partner with Centers for Independent Living and NC4A to organize and conduct training throughout the State.

18.7% of people 65 and older in North Carolina are members of ethnic minority groups.

28. DAAS, in consultation with the Center for Aging and Diversity within IOA, will study the prevalence and location of older minorities, including the non-English–speaking populations, to assess the need for outreach and to design strategies that support the inclusion of these populations in activities and programs for older adults and their family caregivers.

DAAS will study the prevalence and location of older minority adults, including the non–English-speaking populations, to assess the need for outreach and to design outreach strategies that support the inclusion of these populations in activities and programs for older adults.

Along with the rest of the US, North Carolina is experiencing dramatic demographic changes, including growth in minority and immigrant older adult populations. Unfortunately, our knowledge about many specific groups is limited, especially about the health and well-being of immigrant populations. Few targeted programs or strategies have been developed to address the needs of these older adults, especially those whose risk of poor health is increased by language and cultural barriers, isolation, poverty, and the lack of access to preventive care. Further study of the prevalence, geographic distribution, and needs of minority seniors is imperative if North Carolina is to prepare adequately to meet the challenges of their growing numbers as well as respond to aging immigrant populations.

In general, there are limitations to the Census data available about aging immigrant populations, because the number of immigrants is likely underreported, and some are undocumented. More information is also needed on specific aging subpopulations within the State. For example, not all Asian/Pacific Islanders or Hispanics have the same cultural or linguistic backgrounds. Many come from different countries of origin, speak different languages, have different national histories, and are accustomed to varying types of health care practices.

Knowledge about the needs of various older minorities, especially immigrants, is lacking and requires our attention. Health care and human services professionals also face challenges in working effectively with minority populations owing to lack of interpreters, low patient health literacy, and lack of cultural understanding on

the part of the professionals. This is especially problematic given the rise in the incidence of chronic illnesses such as hypertension, diabetes, obesity, chronic lung diseases, cardiovascular diseases, and cancer, all of which respond better to treatment if screened and diagnosed early.

To meet the challenges posed by increasing numbers of older persons from diverse cultural backgrounds, we must form new partnerships, identify providers' training needs, and disseminate information about promising practices. Key partners will include organizations that serve and/or are based in minority communities, faith-based organizations, State agencies, local businesses, and others who already work directly with local elders and have established trusting relationships.

Studying the number and location of older minorities, as well as their current health status and use of health and human services, will help us identify barriers, formulate outreach strategies, and develop programs and services to reduce health disparities and promote successful aging.

29. DAAS will collaborate with the NC Senior Games and NC4A to publicize and strengthen senior participation in artistic endeavors through SilverArts, which emphasizes many areas of creative expression including heritage arts, literary arts, performing arts, visual arts, and cheerleading.

Conceived in 1986, SilverArts, "a celebration of the creative expression of seniors in North Carolina," is a major component of the traditional athletic competition of North Carolina Senior Games (NCSG). In a philosophy that strives to keep seniors healthy, active, and involved, SilverArts unites the athlete and artist in a program that recognizes the similarities of both endeavors: discipline, dedication, and pride in one's accomplishments. SilverArts provides a stage for the creative talents of the visual, heritage, literary, and performing artists. Encouragement and recognition of creative potential and accomplishment is the goal of the SilverArts program.

Table 4. Participation in SilverArts Events, 1998–2006

SeniorArts Events	1998	2000	2004	2006
Visual Arts	580	691	669	720
Literary Arts	304	309	317	517
Performing Arts	1060	957	1073	1112
Heritage Arts	786	737	732	694
Cheerleading	83	83	48	84
Total SilverArts participants	2730	2694	2791	3026
Total Senior Games registrants	8280	8598	9592	10353
% SilverArts participants	33%	31.3%	29.1%	29.2%

A SilverArts program need not, and perhaps should not, rely solely on standard arts events as models for their content, format, and philosophical base. In short, the core of a SilverArts program should be a celebration of personhood as expressed through artistic creativity.

Regardless of its structure or content, SilverArts is a very significant part of the total Senior Games program. In addition to giving seniors a venue for celebrating their creative talents, it inspires people of all ages to consider the life-long benefits of artistic expression. NCSG is excited about the potential of the SilverArts for intergenerational interaction positively affecting citizens of all ages across the State. As such, SilverArts contributes to the total wellness of the whole community.

30. DAAS will work with senior center directors across the State and NC4A to increase the number of Senior Centers of Merit and/or Excellence.

One of the most important policy goals for DAAS is to improve the quality of aging and adult services and programs. Senior centers are vital to this goal because they provide community focal points for older adults (and often their younger caregivers) to learn more about services and programs to maintain independence as long as possible. In addition, center activities help participants maintain or improve their health through exercise, health screening, and information on common conditions older adults face, as well as through meals programs that support adequate nutrition, and educational and social activities that contribute to continued emotional well-being and personal growth.

In fall 1998, DAAS assembled a task force for senior center development to formulate a standard for best practice in senior center operations. The task force established the Senior Center Certification Program, by which senior centers could be certified at the level of Merit or Excellence. Meeting the requirements for certification, which must be reevaluated every three years, strengthens the capacity of senior centers by providing a set of measurable indicators of best practice for five major operational areas: outreach and access to services; programs and activities; planning, evaluation, and input from older adults; staffing; and operations. As of January 2007, there were 163 recognized senior centers in 97 counties in North Carolina, 39 of which were Centers of Excellence, and 8 Centers of Merit. North Carolina is recognized as a national leader in strengthening senior centers through this program, along with DAAS's Ann Johnson Institute for Senior Center Management. Under experienced managers, certified centers have played an important part in piloting DAAS's livable and senior-friendly communities initiative.

Many centers, however, struggle with limited financial resources that are often uncertain from year to year. As they begin to serve aging boomers, centers will require not only increased, stable financial resources but more staff time and improvements in facilities and programs. Centers certified by the State receive a small financial incentive to assist with funding deficits and enhance the delivery of services and programs. Still, improved funding for established and developing centers will be necessary for centers to serve the coming wave of boomers, as well as to be leaders in the development of communities that optimally accommodate residents of all ages.

"In 1965,

the Older Americans Act

saw senior centers

as vital to the coordination

of services.

The focal point concept

of senior centers

is still critical,

and the State's certification program and

training support this idea."

Ann Johnson, Chair
Governor's Advisory Council on Aging (GAC)

Access and Choice in Services and Supports

The best support is the right support: just enough of the right assistance to be effective, provided in the way consumers prefer to receive it, at just the right time. Developments in technology and a user-friendly environment promote both access and choice. Objectives in this section present additional ways in which State agencies plan to do their part in building on programs and approaches that have proven effective.

Major Accomplishments (2003–2007)

- ✓ DHHS secured more than $5 million in federal grants to address many of the recommendations of the *2001 Long-Term Care Plan for North Carolina* (www.nciom.org/ltcfinal.pdf). These grants have supported: Real Choice Systems Change, Aging and Disability Resource Connection development, Community-Integrated Personal Assistance Services and Supports, the Medicaid Rebalancing Initiative, the Nursing Facility Transitions project, Integrating Long Term Supports with Affordable Housing Grant, and most recently, Systems Transformation.
- ✓ DAAS received additional federal support to expand Project C.A.R.E. (Caregiver Alternatives to Running on Empty) to offer information, counseling, and respite to family caregivers of persons with Alzheimer's disease and other dementias in 10 counties—achieving national recognition for this demonstration project.
- ✓ The NC General Assembly has supported expansion of the State/County Special Assistance In-Home Program as a cost-effective alternative to adult care home placement so that 1,500 participant slots are now available among 87 counties.
- ✓ DHHS has undertaken several efforts to introduce and strengthen self- and consumer-directed support options, including preparation of *NC Legislative and Rule Analysis: Findings and Recommendations for Consumer-Directed Supports* (www.ncdhhs.gov/ltc/Summary_Major_Findings_2004.pdf), the pilot of Medicaid CAP Choice in Cabarrus and Duplin counties, and the pilot of self-directed care using HCCBG in Cabarrus County.
- ✓ The NC General Assembly took several steps to strengthen adult day services, including increasing the daily reimbursement rate and funding a study and training initiative.
- ✓ In 2006, the NC General Assembly increased State funding for the Home and Community Care Block Grant by $4 million.
- ✓ DMH/DD/SAS established a specialized enhanced behavioral care unit at a nursing facility to assist people previously served in State hospitals' certified nursing units.
- ✓ DMH/DD/SAS established Geriatric Mental Health Teams at Local Management Entities to provide communities with specialized services, technical assistance, and consultation related to the needs of the older adult population.

Objectives (2007–2011)

31. Appropriate DHHS agencies will work together to ensure that NC's long-term services and supports system is responsive to the diverse needs, values, supports, and preferences of families and friends assisting frail elders and adults with disabilities by incorporating a caregiver assessment/risk screening into family-centered care plans across DHHS and by expanding Project C.A.R.E. and other caregiver supports.
32. North Carolina will have six trusted and visible Aging and Disability Resource Connections (ADRCs)—federally known as Centers—that streamline access to long-term services and supports and empower individuals and their families to make informed choices; Senior Centers of Merit and Excellence will be examined for their readiness to serve as possible locations in which to further establish the ADRC functions.
33. To insure that consumers have an array of quality services and supports, OLTS, DMH/DD/SAS, DAAS, DMA, DVR, local CAP-DA lead agencies, LMEs, and others will develop policies and procedures that incorporate self-directed/consumer-directed models as a service delivery option.
34. The State-County Special Assistance In-Home Program for Adults (SA/IH) will be successfully initiated in all 100 North Carolina counties.
35. Programs with the potential to strengthen Adult Day Services as a viable component of the continuum of long-term services and supports will be evaluated and implemented as feasible.

31. Appropriate DHHS agencies will work together to ensure that NC's long-term services and supports system is responsive to the diverse needs, values, supports, and preferences of families and friends assisting frail elders and adults with disabilities by incorporating a caregiver assessment/risk screening into family-centered care plans across DHHS and by expanding Project C.A.R.E. and other caregiver supports.

Family caregivers provide about 80 percent of all long-term services and supports for chronically ill, frail, and disabled adults, according to L. Thompson's 2004 study. Peter Arno's updated estimates (2006) suggest that North Carolina's family caregivers provide over 900 million hours of care at an economic value of $8.9 billion annually.

Family caregiving is certainly not a new phenomenon in our society, but caregiving families and the issues they confront have radically changed. With medical advancements, not only are families providing care for much longer, but they are managing complex medical conditions and complicated treatments and tasks at home. Women, who provide most of the care, are now in the workforce in greater numbers than ever before. Today's workforce is very mobile, often separating families and disrupting natural support systems.

Caregiving can be rewarding and is often considered to be just "what we do for our relatives and friends." However, caregivers today face much more stress, which leads to serious mental and physical health concerns, and caregiving can be costly when caregivers quit work, lose their own health insurance,

and forfeit retirement income. These negative consequences of caregiving are compounded when the family is caring for a person with dementia, which is the case for about 40 percent of all caregivers.

A system of supports must be responsive not only to the person whom the family is assisting, but to the family members as well. Caregivers have diverse needs, values, and preferences. All people who request assistance through programs of DHHS should receive an assessment and risk screening of the family caregiving situation, which would then be incorporated into person- and family-centered plans.

Family caregivers provide at least 80% of all long-term services and supports for chronically ill, frail, and disabled adults.

Additional strategies for specific support for caregivers of people with dementia might include:

- strengthening NC's Alzheimer's Support Network (comprised of two Alzheimer's Association Chapters and the Duke Family Support Program) through an increase in State funding
- expanding NC's Project C.A.R.E., which currently serves low-income rural and minority family caregivers of people with dementia in 10 western counties
- establishing a staff position among the NC Alzheimer's Association Chapters for a person who would focus solely on State-level program and policy development for people with dementia and their caregivers
- working with the national and State Alzheimer's Associations, NC4A, and others to develop tools to assess and promote dementia-capable communities as part of the livable and senior-friendly communities concept.

32. North Carolina will have six trusted and visible Aging and Disability Resource Connections (ADRCs)—federally known as Centers—that streamline access to long-term services and supports and empower individuals and their families to make informed choices; Senior Centers of Merit and Excellence will be examined for their readiness to serve as possible locations in which to further establish the ADRC functions.

Getting information about and access to long-term services and supports is a confusing and complex process. North Carolina's *2001 Long-Term Care Plan* recommended the development of a multiple-portal-of-entry system to provide a uniform process for gaining information on options for care, as well as seamless access to publicly funded home and community-based services and institutional care.

In 2004 the Office of Long Term Services and Supports secured the Aging and Disability Resource Center (ADRC) Grant, a cooperative effort of AoA and CMS, to assist North Carolina in creating a coordinated system of information and access for all persons seeking services and long-term supports, to minimize confusion, enhance individual choice, and support informed decision making.

DAAS, DMA, and the Office of Rural Health and Community Care (ORHCC) have partnered to implement ADRCs. Currently there are two pilots, a rural model in Surry County and an urban model in Forsyth County. Both pilots follow the "no wrong door" approach and use the term *connection* rather than *center* in the local name of the project. This is a concept and term accepted by DAAS for use in promoting ADRCs. The ADRC model is planned to coordinate closely with DMA's uniform screening tool and the emerging chronic care management program developed by ORHCC.

With support from a CMS Systems Transformation grant, over the next four years an expansion plan will be developed and a name change will be considered to more adequately reflect the "no wrong door" model, with input from various stakeholders and consumers; a readiness assessment will be conducted for senior centers and other organizations to serve as possible sites; and at least four additional ADRCs will be developed within the State (for a total of six). ADRCs will provide a setting where people can seek personal assistance in gaining access to services and supports, while NC care LINK will provide a complementary service through a web portal.

33. To insure that consumers have an array of quality services and supports, OLTS, DMH/DD/SAS, DAAS, DMA, DVR, local CAP-DA lead agencies, LMEs, and others will develop policies and procedures that incorporate self-directed/consumer directed models as a service delivery option.

Further expansion of consumer-directed services is in keeping with the Long Term Services and Supports (LTS) Vision Statement, adopted by the LTS Cabinet in February 2006: "People of all ages and their families [will] live in inclusive, responsive communities where they have choices and control over their long term services and supports."

Among the options already available in North Carolina are:

- DVR's Independent Living Program
- Council on Developmental Disabilities and DMH/DD/SAS's self-determination pilots
- Development of a self-directed option within CAP–DA Medicaid waiver (CAP Choice)
- Cabarrus County Department of Aging's self-directed option pilot using HCCBG funds
- Self-directed options through Project C.A.R.E.
- The State-County Special Assistance In-home Program (SA/IH).

Much of what has been done to date has focused on certain populations, relied on specific funding streams, or been part of time-limited projects. Nonetheless, the successes achieved through the self-direction pilot projects of the Real Choice Systems Change grant (2001–2005) and other activities will provide the basis for expansion of self-directed service options to individuals of all disability and age groups, while the recently awarded CMS Systems Transformation grant will serve as a catalyst for that development.

34. The State-County Special Assistance In-Home Program for Adults (SA/IH) will be successfully initiated in all 100 North Carolina counties.

The SA/IH program provides a cash supplement to help people with low incomes, who are at risk of entering an adult care home to remain in their own homes if they can do so safely with additional supportive services and discretionary income. This program helps people with income levels that would qualify them for Medicaid with such living expenses as food, shelter, clothing, and other daily necessities. Checks are sent monthly to eligible people living in private homes. The amount of the check is based

on income and need. A case manager at the county department of social services conducts a comprehensive services assessment and works with the client and family to determine how the payments will be used. The case manager establishes the amounts and monitors to assure that payments are used as intended. The case manager's role is essential in helping the clients remain at home, and all SA/IH recipients receive ongoing case management.

In 2006, 87 counties had or were initiating SA/IH programs, and it is important to initiate the program in the remaining counties. Relatively small monthly payments (the average is $276.91) can often delay placement in residential care that would cost $426.18 per month, on average. Additionally, people who participate in this program rate their quality of life significantly higher in terms of feelings/emotions, physical and social environment, and community access. They believe they have more control over their lives.

35. Programs with the potential to strengthen Adult Day Services as a viable component of the contiuum of long-term services and supports will be evaluated and implemented as feasible.

Day services for adults, which sometimes may include limited assistance with health and personal care needs, support the independence and social, physical, and emotional well-being of people who have impairments that prevent them from living independently without supervision. Participation in such programs often provides relief to family caregivers, allowing adults with impairments to continue living at home while enabling caregivers to take a break from their responsibilities or continue their employment.

Although there is little question about the importance and value of adult day services, the number of programs has decreased, from 125 in 2000 to 107 in February 2007, despite an increase in the population they are designed to serve. Clearly there is a need to make this component of the continuum of long-term services and supports more visible to the public and to identify and nurture models that strengthen it.

The number of adult day service programs has decreased from 125 in 2000 to 107 as of February 2007, despite an increase in the population they are designed to serve.

Four current programs hold promise:

- As of November 2006, DMA had formed a work group to develop a policy for Medicaid that includes specifications and requirements for delivery of respite services. The inclusion of respite through adult day services is one of the items to be discussed. There is also potential development of an overnight respite program that could benefit the families of participants attending adult day service programs.

- Programs for the All-Inclusive Care for the Elderly (PACE) serve seniors with chronic care needs by providing access to the full continuum of medical care, social services, and support services in the home and community. PACE programs are centered around an adult day health program that provides primary physician's and skilled nursing care; physical, occupational, and recreational therapies; meals; nutritional counseling; social work; and personal care to individuals 55 and older who meet level-of-care criteria for nursing facility care. The programs maintain contracts with community providers and arrange for all of the care PACE enrollees require. They are the most comprehensive and integrated of the Medicaid long-term care home and community-based service programs. A major factor in establishing and sustaining PACE programs is the necessary start-up funding and the level of risk assumed for participants' care. In the 2004 short session, the NC General Assembly directed DMA to develop a pilot program to implement PACE, and there are currently two sites, in Wilmington and Carrboro, set to open in late 2007, while a third, in Southern Pines, is still in the early stages of planning.
- Project C.A.R.E. is a federally-funded demonstration program, operating in 10 western counties. It uses a self-directed, family consultant model to provide comprehensive respite support to family caregivers of people with dementia. Families receive up to $2,000 annually to spend on respite care. Adult day services are among those commonly used. A review of Project C.A.R.E. data demonstrate that when the funding is used for the purchase of adult day services, it goes further. At an average cost of $40.00 per day, the funds available to qualifying families could potentially purchase full-time day care for more than two months. Respite programs, such as Project C.A.R.E., strengthen adult day services by providing funding from another source.
- Finally, the federal Lifespan Respite Care Act of 2006, passed with strong bipartisan support, promises to help states develop Lifespan Respite Programs "as coordinated systems of accessible, community-based respite care services for family caregivers of children and adults with special needs."

Public Accountability and Responsiveness

Taxpayers and consumers want to know their hard-earned money is being spent wisely. As the demand for publicly supported services grows, State and local governments are facing hard choices about how to distribute limited revenues. Good planning for and good stewardship of public funds require agencies and organizations to be able to track how those funds are spent, with what result, and use that information to plan again. Objectives in this section focus on improving the quality of services, the planning process, and the data gathering that support them.

Major Accomplishments (2003–2007)

- ✓ In September 2003, DHHS merged Adult Social Services, formerly in the Division of Social Services, with the Division of Aging to create the Division of Aging and Adult Services.
- ✓ The Governor's Advisory Council on Aging and others sponsored a pre-White House Conference on Aging and other events to gather information on a broad range of aging issues from consumers, advocates, and service professionals to equip North Carolina's delegates to the 2005 White House Conference on Aging.
- ✓ DAAS worked with others to strengthen planning for aging, including management of the DHHS Communications and Coordination Initiative to Strengthen Long-Term Care for Families (piloted in Mecklenburg, New Hanover, and other counties), development of a *Planning Basics Guide* (http://ssw.unc.edu/cares/planningbasics/index.htm), and selection as one of eight states to help the US Administration on Aging develop a comprehensive and integrated planning model for aging.
- ✓ DAAS continued to be a national leader among State Units on Aging in its seventh year of participating in the Performance Outcome Measurements Project (POMP).
- ✓ SHIIP fully integrated the Senior Medicare Patrol program, a preventive program to reduce Medicare fraud and abuse, into their array of services.
- ✓ With support of the NC General Assembly, DMA took steps to strengthen CAP–DA and Personal Care Services (PCS), including use of a new formula for allocating CAP–DA slots and tightening eligibility criteria for PCS.
- ✓ Working with the DHHS Quality Standards Work Group, the Carolinas Center for Medical Excellence (CCME) developed a consumer guide on Nursing Home Quality Measures.
- ✓ A special Centers for Disease Control and Prevention (CDC) study used NC family caregivers to assess caregiver stress, services, and needs for a national report.
- ✓ Supported by the NC General Assembly, DFS significantly increased its capacity through new regulatory positions to conduct annual surveys on adult care homes; DFS tightened home care licensure requirements to improve the overall quality of care.

Objectives (2007–2011)

36. DAAS will work with others to develop tools and training materials for the Quality Improvement Consultation Initiative in Adult Care Homes, to be piloted in four counties and then phased in among up to 20 more.
37. DAAS will integrate goals and objectives from County Aging Leadership Planning Teams, as well as Regional Area Plans under the livable and senior-friendly communities framework; develop a logic model that links local, regional, and state objectives with AoA priority areas; and build a web-based clearinghouse to support comprehensive planning associated with the eight components of the livable and senior-friendly communities model.
38. DAAS will work with IOA, the North Carolina Center for Creative Retirement, AARP NC, NC Cooperative Extension, NC4A, and others to identify potential future senior leaders and provide training to develop leadership skills and knowledge about aging issues.
39. DAAS and NC4A will identify promising practices from the development of local performance measurement plans in the NC POMP pilot project and develop a set of recommendations based on "lessons learned" to build local and regional capacity for effective performance measurement.
40. DAAS, DIRM, and NC4A will create data-monitoring and tracking reports for HCCBG services from the ARMS database, with the purpose of creating an efficient and effective program-tracking system to be used for planning, monitoring, development, and evaluation.

36. DAAS will work with others to develop tools and training materials for the Quality Improvement Consultation Initiative in Adult Care Homes, to be piloted in four counties and then phased in among up to 20 more.

The Quality Improvement (QI) Consultation Program was established by Session Law 2005-276 [Section 10.40A.(p)] to be implemented by the 100 county departments of social services with all adult care and family care homes. The QI Consultation Program was developed by DAAS in collaboration with the Carolinas Center for Medical Excellence (CCME), with direction from a task force composed of adult care home providers, advocates, departments of social services, State agencies, and other stakeholders. The focus of the work of the task force was better care and quality of life in a safe environment for residents; providing dignity, choice, and independence to increase resident satisfaction; disseminating best practices to improve care; and using standardized instruments to assess and measure the performance of adult care homes and outcomes for residents.

Well-developed QI programs have improved outcomes in clinical care, safety, and quality of life in long-term care settings. The initial program chosen by the task force and developed by DAAS and CCME focuses specifically on medication safety. Information obtained from DFS, Adult Care Licensure Section, revealed a 20 percent deficiency rate in medication management among adult care and family care homes surveyed between October 2005 and March 2006.

A pilot to determine whether the QI Consultation Program is adequate and can be replicated on a statewide basis will be conducted through four county departments of social services. Six to ten adult care or family care homes in each county will be invited to participate. Based on the outcome of these pilots, the program will be extended to 20 counties and additional topics will be developed as well.

37. DAAS will integrate goals and objectives from County Aging Leadership Planning Teams, as well as Regional Area Plans under the livable and senior-friendly communities framework; develop a logic model that links local, regional, and state objectives with AoA priority areas; and build a web-based clearinghouse to support comprehensive planning associated with the eight components of the livable and senior-friendly communities model.

In fall 2005, DAAS was the recipient of a three-year planning grant from AoA to work with Area Agencies on Aging to develop a comprehensive approach to planning for aging services that effectively integrates the three levels of government activity—local/county, regional, and State. DAAS chose to develop its approach within the existing framework for livable and senior-friendly communities. DAAS believes that planning across the levels of government will maximize the use of resources, improve the aging network's capacity to deliver services to adults and family caregivers most in need, and expand the aging network's capacity for collaboration. Developing a consolidated planning process will be especially important in the coming years as our population ages.

These are among the areas for change that would improve the planning process:

- Many counties have quite limited planning for aging—most often tied to HCCBG funding decisions. NC's AAAs are facilitating development of County Aging Leadership Planning Teams who are representative of the local aging population and who can examine and influence important aging issues.
- Currently, State and local planners in aging organize their efforts in different ways—by content area at the State, but by general strategy locally. This difference in perspective and organization makes it difficult to use local or regional analyses as the basis of planning for the State. Working together to identify a common planning method will make for more coordinated plans.
- Many planning efforts are still project-, program-, or funding-specific. The General Assembly consolidated funding from the Older Americans Act (OAA), the Social Services Block Grant (SSBG), and State appropriations into the HCCBG in 1991, so use of funding from these sources could be planned at once. However, smaller successful initiatives such as the ADRC and the Alzheimer's Disease Demonstration Project are not included in a larger, comprehensive plan. It will be important to develop ways to plan that include the whole repertory of available resources and models.
- Planning and evaluation should be closely linked because of their interdependence, yet most planning is neither outcome- nor evidence-based. Strengthening the State's ability to conduct applied research to chart progress toward goals and effectiveness of services would necessarily improve planning.
- Consumer involvement is vital to effective planning. There are both State and regional advisory councils on aging whose membership includes older adults. Increasing their involvement in planning and connecting the work of these councils with planning at the State level would be one way to increase input from consumers of aging services, as would outreach to other stakeholders.

DAAS will continue its partnership with NC4A and other stakeholders, including the planning grant's national work group, to develop a coordinated planning model within the livable and senior-friendly communities framework.

38. DAAS will work with IOA, the North Carolina Center for Creative Retirement, AARP NC, NC Cooperative Extension, NC4A, and others to identify potential future senior leaders and provide training to develop leadership skills and knowledge about aging issues.

The OAA authorizes State Units on Aging to serve as effective and visible advocates for older adults. In addition, DAAS was originally created and charged to perform an extensive list of functions and duties, including:

> *To stimulate, inform, educate, and assist local organizations, the community at large, and older people themselves about aging, including needs, resources and opportunities for the aging, and about the role they can play in improving conditions for the aging [NCGS 143B-181.1(a)(3)].*

One way DAAS carries out this mandate is to identify potential senior leaders and assist them in becoming effective advocates. In addition, DAAS provides organizational support for two statewide advocacy groups, the Senior Tar Heel Legislature, whose representatives are older adults from each county, and the Governor's Advisory Council on Aging, which conducts hearings and provides advice to the Governor and Legislature. See Appendix D for legislative priorities of these advocacy groups.

DAAS collaborates with other State institutions to develop senior leaders, notably the UNC Institute on Aging, the North Carolina Center for Creative Retirement, AARP NC, and NC Cooperative Extension. IOA sponsors the Senior Leadership Enhancement Initiative, which "recognizes the importance of older adult leadership in addressing issues affecting citizens and provides the support necessary to complement the skills and experiences brought by the participants to the program." The North Carolina Center for Creative Retirement at UNC-Asheville has the "three-fold purpose of promoting lifelong learning, leadership, and community service opportunities for retirement-age individuals." With over a million members, AARP NC is involved in many advocacy activities at the state and local level. NC Cooperative Extension provides leadership development for older adults primarily through its Extension & Community Association, a community-based volunteer association with approximately 6500 members in 85 counties across the State. Members participate in planning, developing, and implementing opportunities to develop leadership skills in older adults.

"Senior leaders can be examples of the strengths of elders while being champions for elders and people of all ages who need help in facing life challenges."

Luci Bearon
Adult Development/Aging Specialist
NC Cooperative Extension

39. DAAS and NC4A will identify promising practices from the development of local performance measurement plans in the NC POMP pilot project and develop a set of recommendations based on "lessons learned" to build local and regional capacity for effective performance measurement.

AoA has partnered with a number of state and area agencies on aging, including DAAS and some of NC's AAAs, to develop and field-test performance measures for state and community programs funded by the OAA. The Performance Outcome Measurement Project (POMP) has helped state and regional partners assess their program performance and also assisted AoA with meeting its accountability requirements under the Government Performance and Results Act and the Office of Management and Budget's program assessment requirements.

From the federal to the local level, tracking of comparable data over time has grown in importance, as agencies strive to demonstrate the benefits of their programs and be accountable for funding. Many funders now use performance information to support budget decisions.

Since federal FY 2001–02, DAAS has participated in the national POMP demonstration project, and there has been great interest in developing performance measurement capacity at all levels of the State aging network. DAAS has partnered directly with eight AAAs to carry out POMP pilots, and almost all AAAs have assisted with aspects of statewide or national surveys involving clients in this State.

In addition to gaining experience with the collection of information through client surveys, DAAS also recognizes the importance of data collected in client registration records that are periodically updated by service providers. To take greater advantage of the existing statewide system of client registration and reporting, DAAS modified its client registration form in late 2006 to incorporate additional information about client and caregiver characteristics and outcomes.

In SFY 2006–07, DAAS partnered with four AAAs in a joint effort to build examples of performance measurements plans "from the ground up." Ten counties from the four regions participated. The plans that they chose to develop focused on a broad range of topics important to their communities, including:

- supporting grandparents raising grandchildren
- promoting health through exercise programs
- assessing the benefits of in-home aide programs
- developing a special needs registry for emergency response
- documenting the worth of senior lunch programs
- combining Census data and service provision data on GIS maps to support local planning.

Recognizing the value of locally developed priorities and tracking mechanisms, DAAS intends to work with the four regions to identify promising practices from the project. A description of the projects and lessons learned will be offered to other AAAs for possible inclusion in future work with local Aging Leadership Planning Teams.

40. DAAS, DIRM, and NC4A will create data-monitoring and tracking reports for HCCBG services from the ARMS database, with the purpose of creating an efficient and effective program-tracking system to be used for planning, monitoring, development, and evaluation.

The Aging Resources Management System (ARMS) of DAAS is being redeveloped as a web-based technology that will begin in 2007. As part of this transition, DAAS and DIRM will develop new demographic and statistical reports. The expanded Client Registration Form (DAAS-101) will collect new data elements useful for planning, monitoring, development, and evaluation. Here are some examples of each.

Planning. The OAA, reauthorized October 15, 2006, charges states to target services to a new priority group of older adults, those with limited English proficiency. Client registration information in the new ARMS will identify the "primary language spoken" and so provide the number of older adults with limited English proficiency by county. This information will be especially useful in developing outreach programs to unserved and underserved older adults.

Monitoring. A key element in monitoring federally-funded services is determining compliance with 14 criteria identified by the Office of Budget and Management (Circular A-133). Data collected through ARMS include eligibility of clients, program income collected and reported, and units of service provided. Reports from the enhanced ARMS will make monitoring of these criteria more efficient.

Development. DAAS creates data packets annually to be used by each county in planning services and awarding contracts. These packets list all services currently funded and will assist county planning committees in identifying both service gaps and efficiencies. The new ARMS will facilitate production of these reports.

Evaluation. Current data from ARMS provides DAAS and its stakeholders with information about the number of older adults and caregivers served, but it does not contain information that would help understand the outcomes of receiving services. The new ARMS will allow DAAS and others to gather information about why clients leave the system.

From POMP, DAAS learned in 2004 that nearly 50% of NC home-delivered meals recipients depend on the noon-day meal for half of their daily food intake. The federal requirement is that the meal provides one-third of the minimum nutritional allowance.

IV. Conclusion: A Call to Action

For North Carolina and its communities to be as livable and senior-friendly as we would like, a great deal of work is yet to be done. This *Plan* was developed with input from other State agencies and the 17 Area Agencies on Aging, as well as with participation from consumers and their advocates, service providers, and educators. The work necessary to achieve the *Plan's* 40 objectives must also be done collaboratively across disciplines and organizations. By accomplishing these objectives over the next four years, the State will help meet our collective goals of drawing upon the talents and resources of seniors, while enhancing services for those who are most vulnerable; valuing diversity, while addressing disparity; being responsible stewards of resources, including support of family caregiving; and helping boomers prepare for their future.

The *2007–2011 State Aging Services Plan* was created with the needs of current and future older North Carolinians in mind. For the *Plan* to be successful, policymakers, public and private entities, consumers, and other interested stakeholders must do their part to support the work.

North Carolina has a large, diverse older adult population that will soon grow rapidly. The 40 objectives included here serve as opportunities for North Carolina to face not only the challenges associated with an older adult population, but also to reap the benefits they offer—that is, to help put the pieces together for livable and senior-friendly communities.

A serious call to action requires participation from all sectors. Executive and legislative leaders have produced a number of studies and reports to guide future steps to prepare for a more logical and efficient service delivery system. Advocates crystallize consumer opinion and priorities to drive future public and private response. Educators and researchers are focusing attention on evidenced-based practice and the training of future practitioners. The faith and business communities share a common understanding that the aging population has important implications for service capacity and need. Our health and human service providers are increasingly realizing the changing demographics, not merely the growing numbers of seniors but, equally significant, their increasing diversity. Providers, planners, and policymakers are becoming more aware of the various needs and interests of seniors and their families and also of the economic disparities that exist in the population. Only with the enlightenment, expectation, and support of various stakeholders can we hope to achieve the *Plan's* objectives.

"Join us in planning for and supporting the development of livable and senior-friendly communities to the benefit of North Carolinians of all ages."

Carmen Hooker Odom, Secretary

North Carolina Department of Health and Human Services

Appendixes

The Appendixes contain a number of documents, each of which can stand alone as a valuable resource and also provide support for the main text. They were developed and assembled to provide the reader with a greater understanding of issues related to aging in North Carolina and information on the aging network and the various services and programs each organization provides. Here is a brief description of each appendix.

A. Inventory of State Resources for Older Adults. This extensive compilation of organizations identifies providers of services to and information on the older population. Each organization is briefly described with contact information. Where different programs within an organization have different functions, all are described. This resource, with hot links, is available on the Division of Aging and Adult Services (DAAS) web site (www.ncdhhs.gov/aging).

B. Area Agencies on Aging. The 17 AAAs in the State with the directors and their contact information and a list of counties in the regions.

C. Emerging Issues. In the development of the 40 objectives of this *Plan*, an initial step involved researching Exhibit 8 in each of the 17 Regional Area Plans. This Exhibit, entitled "Senior-Friendliness and Needs Assessment," was produced by each of the AAAs to reflect areas of concern and need among older residents in the counties within their region. The issues are listed exactly as they were presented in the Area Plans. DAAS staff did not edit the information from Exhibit 8. Input from the Area Plan exhibits are organized within each of the eight components of the livable and senior-friendly communities framework. This provided a useful and pertinent foundation from which the objectives were derived.

D. Views of Advocates. A description of each of four groups that provide support for aging-related issues to the North Carolina General Assembly. There is a grid that lists the 25 key recommendations for the 2007–2008 session of the Legislature and which group supports each.

E. Expenditures by Funding Source, Service, and Service Category for People Age 60 and Older in SFY 2005–06. The table of aggregated data for the State shows where public funding for services for older adults comes from and how it is spent, using the most recent fiscal year at the time this document was written. Annually, DAAS compiles data by county on the expenditures for people 60 and older from seven State agencies. The information is presented to the county managers and Commissioners in all 100 counties each February 15 for their use in determining how Home and Community Care Block Grant (HCCBG) funds will be allocated among the service areas in the coming fiscal year. Updated annual information on each county can be found on the DAAS website.

F. Acronyms. The full name of each organization for which an acronym is used in the text, arranged by type of organization.

G. References. A list of the sources of information used in developing of this *Plan*.

Appendix A: Inventory of State Resources for Older Adults

This inventory lists many of the services and programs administered for older North Carolinians by agencies within State government, and especially among the divisions and offices of the Department of Health and Human Services. A table of aggregated expenditure date for services administered by State agencies for older adults can be found as Appendix E.

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THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS)

www.ncdhhs.gov

DHHS advocates for citizens age 60 and older and their families and helps younger generations prepare to enjoy their later years. Its divisions and offices enrich the lives of older North Carolinians by:

- supporting safe and stable living arrangements
- enhancing self-sufficiency
- enhancing quality of life
- supporting family caregivers
- safeguarding the rights and interests of older people
- involving older people in the planning and evaluating of programs
- promoting health care for older people
- promoting independent living.

Division of Aging and Adult Services (DAAS)

www.ncdhhs.gov/aging

Home and Community Services

Working with 17 Area Agencies on Aging (AAAs) and more than 430 public and private local organizations, DAAS supports a wide range of home and community-based services. The division also helps develop and strengthen senior centers as resources for communities all across the State. The array of services and programs offered varies from one county to another based on local need and other factors particular to a county. Described below are the various services that are available under the State's Home and Community Care Block Grant (HCCBG), authorized by NCGS 143B-181.1(a)(11).

Adult Day Care and Adult Day Health Care provide organized programs of services during the day in community group settings for the purpose of supporting the personal independence of older adults and promoting their social, physical, and emotional well-being. Programs must offer a variety of activities designed to meet the individual needs and interests of the participants, including referral to and assistance in using other community resources. In addition, providers of adult day health services, as the name implies, offer health care services to meet the needs of individual participants. These two adult day services are considered to be "core long-term care services." Providers of adult day care must meet North Carolina State Standards for Certification, which are administrative rules (10 NCAC 42E) set by the Social Services Commission and enforced by DAAS. Providers of adult day health care must similarly meet administrative rules set by the Social Services Commission (10 NCAC 42Z) and enforced by the DAAS. Routine monitoring of compliance is performed by adult day care coordinators located at county departments of social services (DSSs). Centers may be certified to provide adult day care (49 in the state on January 1, 2007), adult day health care (3), or both types of care (55); as of January 1, 2007 there were a total of 107 programs in 57 counties. There were 95 older adults reportedly waiting for adult day care services under the HCCBG (up from 55 in 2004), and 69 waiting for adult day health services (up from 24 in 2004).

Another funding source for adult day services is the State Adult Day Care Fund, which is budgeted through the Division of Social Services and administered by the DAAS. In SFY 2005–06, county departments of social services spent over $3.8 million from the State Adult Day Care Fund to support 1,284 older and disabled clients of adult day care and health.

Care Management, another "core long-term care service," is a coordinated care function that incorporates case finding, assessment, care planning, negotiation, care plan implementation, monitoring, and advocacy to assist clients and their families with complex needs in obtaining appropriate services. In SFY 2005-06 224 people in 9 counties were served by care management services under HCCBG.

Congregate Nutrition provides a meal (typically lunch) that contains one-third of the Recommended Dietary Allowances in a group setting to persons age 60 and older and their spouses. In SFY 2005-2006 26,778 participants were served and $10,919,120 in HCCBG funds was spent on these services. The DAAS is also working with the Division of Public Health and the North Carolina Department of Agriculture to operate the Senior Farmers' Market Nutrition Program for older participants with low income. In SFY 2005–2006 the Farmers' Market program provided free locally grown fruits and vegetables to 2,965 participants in 19 counties.

Group Respite uses professional management and trained volunteers to offer temporary, part-time relief to unpaid, primary caregivers of cognitively or physically impaired older adults and to provide meaningful social and recreational activities for those receiving care. Sometimes called "Caregiver's Day Out," group respite programs must be open a minimum of one day a week for at least three hours; programs may not exceed four days a week for five hours per day without being certified as adult day care centers. Considered to be a "core long-term care service," group respite became a reimbursable service under HCCBG in July 1996.

Health Screening offers general medical testing, screening, and referral to promote early detection and prevention of health problems in older adults. In SFY 2005–06, one county used HCCBG to offer health screening. In addition, under Title III-D of the Older Americans Act, $457,265 was spent in SFY 2005–06 for *Health Promotion and Disease Prevention* programs that support a broad array of activities to assist older adults in maintaining and improving their health and wellness. Health promotion and disease prevention programs also help older adults identify health problems or potential problems and offer effective interventions to address these problems. Funding for Title III-D is made available to AAAs who contract with local service providers. At least 23.62 percent of the health promotion and disease prevention funds must be used for medication management programs. Other common services funded by health promotion and disease prevention funds include health screening, nutrition education, exercise classes, and Senior Games.

Home-Delivered Meals, a "core long-term care service," provides a meal (typically lunch) that contains one-third of the Recommended Dietary Allowances to homebound older adults. In SFY 2005–06, 16,977 people were served. Participants contributed a total of $692,162, which helped extend the service to others. Across the State, 3,283 older adults were waiting for home-delivered meals as of January 2007 (up from 1,995 in 2004).

Home Health, a "core long-term care service," is skilled health care prescribed by a physician and provided in the home of an older adult in need of medical care. Allowable services include skilled nursing; physical, occupational, and/or speech therapy; medical social services; and nutrition care. In SFY 2005–06, only one county chose to use some of its HCCBG to offer home health skilled nursing care to 29 older persons at the cost of $24,295.

Housing and Home Improvement, a "core long-term care service," assists older adults with obtaining or retaining adequate housing and basic furnishings. Types of assistance include providing information about available options for housing with or without services and how to finance them; helping to improve landlord/tenant relations; identifying substandard housing; securing correction of housing code violations; assisting with finding and relocating to alternative housing; and providing labor and/or materials for minor renovations and/or repair of dwellings to remedy conditions that create a risk to the personal health and safety of older adults. In SFY 2005–06, $816,496 of HCCBG funds helped 1,323 older households with housing and home improvements. As of January 2007, 819 older adults were waiting for housing and home improvement services under the HCCBG (up from 650 in 2004).

Information and Assistance, a "core long-term care service," helps older adults, their families, and others acting on their behalf with information about programs and services and to access them as appropriate. In SFY 2005–06, $1.5 million in HCCBG funds were used in 40 counties to offer information and assistance.

In-Home Aide Services, a "core long-term care service," involves the provision of paraprofessional services that assist functionally impaired older adults and/or their families with essential home management, personal care, and/or supervision to enable the older adult to remain at home as long as possible. In SFY 2005–06, counties spent $17.2 million from the HCCBG to provide in-home aide services to 9,734 older persons (up from 8,022 persons in SFY 2002–03.) As of January 2007, 4,812 older adults were waiting for in-home aide services under the HCCBG (up from 2,758 in 2004).

Institutional Respite Care temporarily places older adults who require constant care and/or supervision in long-term care facilities to provide their unpaid, primary caregiver with relief from caregiving responsibilities. In SFY 2005–06, one county used $224,479 from HCCBG to offer institutional respite care and served a total of 64 older persons. Respite is considered to be a "core long-term care service."

Legal Services provides help to older people with the greatest economic and social need who are not otherwise eligible for assistance. DAAS and the AAAs allocate a percentage of the Older Americans Act funds to these services. During SFY 2005–06, $416,804 was spent on legal services. Legal Services is not funded under HCCBG.

Mental Health Counseling incorporates care consultation, evaluation, and outpatient treatment to older adults who are experiencing mental health problems. In SFY 2005–06, no county used HCCBG funds to offer mental health counseling.

Senior Center Operations and Development supports the operation of multipurpose senior centers as well as their acquisition, construction, expansion, renovation, and the purchase of equipment. Multipurpose senior centers are community facilities established to organize and provide a broad spectrum of services focused on health, social interaction, nutrition, education, and recreation. Their primary objectives are to centralize provision of services that address the special needs of older adults; provide opportunities for older adults to become more involved in the community; and prevent loneliness and premature institutionalization by promoting personal independence and wellness. DAAS administers three areas of funding for senior centers—Senior Center Outreach and General Purpose Funds from the State, and Senior Center Operations under the HCCBG and funded by the Older Americans Act. For SFY 2005–06 $100,000 was allocated for Senior Center Outreach and over $1.6 million for Senior Center General Purpose. The SFY 2005–06 expenditure for Senior Center Operations, under the HCCBG and funded by the Older Americans Act, was $4,665,400. This funding goes to 163 centers in 97 counties (3 counties do not have a senior center). Currently DAAS has certified 47 centers—39 Centers of Excellence and 8 Centers of Merit—through a voluntary State certification process designed to strengthen and reward quality senior centers.

Senior Companion Program offers a part-time, volunteer opportunity with a stipend for people age 60 or older with low incomes who are interested in community service. Senior companions provide support, task assistance, and/or companionship to adults with exceptional needs (developmental disabilities, functional impairments, or persons who have other special needs for companionship). In SFY 2005–06, seven counties chose to use some of their HCCBG for the senior companion program, totaling $135,035 to serve 80 seniors with special needs.

Transportation, a "core long-term care service," enables older adults to travel to medical appointments, nutrition sites, and other services necessary to daily living. In SFY 2005–06, about $6.3 million in HCCBG funds were used to provide trips for 13,575 older persons (down from 15,284 persons in SFY 2001–02 and 16,302 in SFY 2000–01.) As of January 2007, 56 older adults were on waiting lists for medical transportation and 101 for general transportation under the HCCBG.

Volunteer Program Development supports development and operation of a systematic program for volunteer participation, involving volunteers of all ages in serving older adults while also providing older adults with opportunities for community service. In SFY 2005–06, 10 counties (up from 6 in SFY 2001–02) used some of their HCCBG for development of volunteer programs, totaling $158,421.

Family Caregiving. DAAS recognizes that each day more and more North Carolinians face the challenge of providing care to a loved one who needs help because of chronic illness or disability. North Carolina's approximately 840,000 family caregivers provide an estimated 80 percent of all long-term services and supports to their older family members. With the 2000 reauthorization of the Older Americans Act (OAA) and its Title III-E, the Family Caregiver Support Program (FCSP) focuses on this essential population. In SFY 2005–06, FCSP used $3.8 million to serve more than 18,600 caregivers through direct services and potentially 1.8 million current and future caregivers through more than 1,000 public awareness events.

The program emphasizes partnerships with other community organizations to leverage this funding source to meet the needs of a large and growing caregiver population. Each of the State's 17 AAAs has a family caregiver resource specialist who helps DAAS build a seamless system of support that meets caregivers' diverse needs including caregiver information, counseling, training, respite, and other forms of relief and assistance that enable caregivers to continue their efforts.

Elder Rights and Special Initiatives

Protecting and securing the rights and benefits of older adults is central to the work performed by the aging network. Through its elder rights activities, DAAS seeks to help vulnerable older adults understand their rights, secure benefits, exercise choice, and maintain autonomy and independence. This work is achieved through a variety of programs and services listed below and others discussed in the section on Adult Services.

Long-Term Care Ombudsman Program consists of state and regional ombudsmen who help residents of long-term care facilities exercise their rights. In addition to being an advocate for residents, they educate the public and facility staff members

about rights and help resolve grievances between residents/families and facilities. In the federal FY 2006, the program handled 3,044 complaints and resolved 79 percent of them without referral to another agency. The LTC Ombudsman Program also provided technical assistance to 16,683 individuals on long-term care issues. The regional ombudsmen, who are located within AAAs, also help support the efforts of Adult Care Home and Nursing Home Community Advisory Committees (NCGS 131E-128 and 131D-3). These local committees, which are composed of volunteers appointed by county commissioners, routinely visit facilities, serve as advocates for residents, help ensure that the intent of the resident's bill of rights is maintained, and work to increase community involvement in nursing homes and adult care homes. There are more than 1,300 such volunteers statewide, with committees in each county.

Elder Abuse, Neglect, and Exploitation Prevention Education. Working with the county departments of social services and other local and state agencies, DAAS and the AAAs provide seminars, materials, and technical assistance on the prevention of elder abuse, neglect, and exploitation.

Legal Services Development. DAAS offers oversight and technical assistance to the legal assistance programs funded through the Older Americans Act, as well as education and training across the State to older adults, professionals, and the aging network.

Consumer Fraud Protection. In 1998, DAAS joined with AARP NC and the Attorney General's Office to establish the NC Senior Consumer Fraud Task Force, with representatives from federal, state, and local law enforcement agencies, aging advocates, the aging network, state and local Better Business Bureaus, and crime prevention agencies. An important goal of the task force is to educate consumers about fraud and other deceptive practices that target seniors.

Victims Assistance Program. In recognition of the need for a coordinated and integrated approach to assisting North Carolina seniors who have been victims of fraud and scams, DAAS and the State Attorney General's Office have developed a Victims Assistance Program, whose goals are to reduce the incidence of fraud and establish a protocol for early detection of signs and symptoms of fraud in the vulnerable aging population. Because people who have been victimized are at greater risk of being victimized again, this initiative provides intense training to volunteers to help them become effective mentors and "buddies" to victims of fraud.

Senior Community Service Employment Program. DAAS administers the Senior Community Service Employment Program (SCSEP) in parts of North Carolina. Federally funded under Title V of the Older Americans Act, SCSEP seeks to place people 55 and older, who are economically disadvantaged, in useful part-time community service positions until they can achieve unsubsidized employment.

Benefits Navigator Program. DAAS offers training to interested volunteers across the State who then provide assistance to seniors and people with disabilities with limited income who may be eligible for additional public benefits. As of January 2007, the Benefits Navigator Program has over 300 volunteers in 65 counties.

Adult Services

Working primarily with the 100 county DSSs, DAAS oversees vital social services programs for older and disabled adults and their families.

Adult Placement Services. All 100 county DSSs help aging or disabled adults find appropriate living and health care arrangements when their health, safety, and well-being can no longer be maintained at home. Placement arrangements are made in adult care homes, nursing homes, and other congregate settings with available services. Adults and their families are counseled to help determine the need for placement, helped to complete medical evaluations and financial applications, and locate and move to new settings. They also may receive counseling to help them adjust to the change. Adult Placement services also include assisting older adults to return to more independent settings in the community or to relocate to more appropriate settings when new levels of care are needed. For SFY 2005–06, 513 clients 60 and older were assisted through adult placement services at the cost of $149,139.

Adult Protective Services. North Carolina has been providing protective services to adults through its 100 county DSSs since 1975, one of the nation's first initiatives to recognize and address the needs of older and disabled adults who had been abused, neglected, and/or exploited. North Carolina's Adult Protective Services statute (NCGS 108A, Sec. 6) provides for services to all adults who are incapacitated by a physical or mental disability. It authorizes county DSSs to evaluate a disabled adult's need for protective services and to provide or arrange for services when necessary. Services include a

thorough assessment of needs, referral to appropriate services, and counseling for the adult and the adult's family. Protective Services are provided in the least restrictive and intrusive manner possible. For SFY 2005–06, 5,454 clients 60 and older were assisted through adult protective services at the cost of $3,146,785.

Guardianship Services. All 100 county DSSs provide public agent guardians who serve as surrogate decision makers for adults who have been deemed incompetent to manage their affairs and take care of themselves. Public Agent Guardians, such as social services, mental health, public health, and county departments on aging directors, may be appointed by the Clerk of Superior Court when relatives or corporations are not available to serve. DAAS manages the DHHS public agent guardian program. Training for all public agent guardians is provided by DAAS. The DHHS Blanket Bond Data Base for all incompetent adults with a public agent guardian is managed by the DAAS. For SFY 2005–06, 1,787 persons 60 and older were assisted with guardianship services at the cost of $1,766,540.

At-Risk Case Management Services. County DSSs assist Medicaid-eligible older and disabled adults who are at risk of or show evidence of abuse, neglect, or exploitation in gaining access to needed medical, social, educational, or other services. These case management activities are directed toward preventing abuse, neglect, or exploitation, or preventing further mistreatment when it has already occurred. Included in the service is an evaluation of the situation, assessment of service needs, development of a comprehensive service plan, assistance with locating and accessing services, coordination of service delivery, and monitoring service provision to ensure that they are delivered, are adequate, and are consistent with quality care. For SFY 2005–06, 2,025 persons who were 60 and older received at-risk case management at the cost of $1,177,017.

Adult Care Home Case Management Services. County DSSs provide a case manager to work in partnership with residents, residents' families, significant others, adult care homes, and community service providers to assure that the needs and preferences of heavy care residents living in adult care homes are being met. Case managers have important and diverse roles with these residents, such as responsibility for conducting broad assessments that can identify the need for other health and social services to benefit residents. Case managers develop service plans and monitor these plans. The service plans outline the primary problems and concerns as identified by residents, residents' families, significant others, adult care homes, and case managers. Service plans identify activities that are intended to address these problems, ultimately improving the quality of care for residents. For SFY 2005–06, 4,757 persons 60 and older received this at adult care home case management services at the cost of $2,739,962.

Transportation. All 100 county DSSs provide transportation services to eligible Medicaid recipients to access medical services, and they offer transportation to other individuals, for other purposes, on an optional basis. County DSSs that elect to provide non-Medicaid transportation offer it as part of a services plan to enable individuals for whom transportation is not otherwise available to have access to medical and health resources; shopping facilities; education, recreational and employment opportunities; and other community facilities, resources, and social services.

Special Assistance. DAAS administers the State/County Special Assistance for Adults program, which provides a cash supplement to help pay for the care of eligible people with low income who live in adult care homes. For SFY 2005–06, 18,056 persons 60 and older were assisted through this program at a cost of $70,999,119.

Special Assistance In-Home Program. The Special Assistance (SA) In-Home program provides an option for in-home care for older and disabled adults who are at risk of placement in an adult care home but who desire to live in a private living setting. Currently, this option is available in 87 counties. To qualify, the person must meet the eligibility criteria for Medicaid and all other SA eligibility requirements. For SFY 2005–06, 697 persons who are 60 and older were assisted through this program at a cost of $1,869,717.

Advocacy

DAAS supports several bodies that are effective advisors and advocates on aging issues. These include the Governor's Advisory Council on Aging and the North Carolina Senior Tar Heel Legislature.

The ***Governor's Advisory Council on Aging*** is authorized by State legislation to make recommendations to the Governor and the Secretary of the Department of Health and Human Services for improving human services to older people, including improved coordination among State agencies. The

Council also studies and recommends how best to promote public understanding of problems affecting older adults and considers the need for new State programs to address these problems. It is comprised of 33 members, with 29 people appointed by the governor, and 2 each appointed by the president pro tempore of the State Senate and the speaker of the State House of Representatives. Among these 33 are 19 at-large members, who are citizens knowledgeable about services supported through the Older Americans Act, and 14 representatives of State agencies or organizations serving older people.

The ***North Carolina Senior Tar Heel Legislature*** was created by the State General Assembly in July 1993 to provide information to older adults on the legislative process and matters being considered by the General Assembly, promote citizen involvement and advocacy about aging issues, and assess the legislative needs of older adults by convening a forum modeled after the General Assembly. Each county has one delegate and many also have an alternate delegate. Delegates and alternates must be 60 or older.

Division of Facility Services

www.ncdhhs.gov/dfs

The Division of Facility Services (DFS) inspects, certifies, registers, and licenses hospitals, nursing homes, adult care homes, mental health facilities, home care programs, and other health facilities. It determines the need for many of these health facilities and services across the State and develops a plan to meet that need. DFS ensures that all patients, including those covered by Medicaid, receive quality care if they reside in a long-term care facility. The Division of Facility Services also maintains the Nurse Aide Registry, as required by State statute.

The State Health Coordinating Council

The Medical Facilities Planning Section of the Division of Facility Services provides staff support to the State Health Coordinating Council, a 27-member body appointed by the Governor. The council and the division are charged by State law with developing policy, criteria, and standards for health service facilities planning; making a determination of need for health services facilities; and developing an annual State Medical Facilities Plan. One of the council's three working committees is focused on long-term care, which includes determining the need for nursing home beds.

Certificate of Need Section

State law requires any person or entity wanting to establish a health care facility, including nursing homes and adult care homes, to first make application for a certificate of need (CON). The Certificate of Need Section reviews and evaluates the applications using such criteria as need, cost of services, accessibility to services, quality of care, and feasibility.

Health Care Personnel Registry Section

This section provides a registry of all persons who have met the federal and State training and competency requirements to perform Nurse Aide I functions. The Registry Section also maintains a list of unlicensed assistive personnel who have been accused of harming, or been found to have harmed, a resident of a facility.

Nursing Home Licensure and Certification Section

This section is responsible for assuring the health, safety, and well-being of persons receiving services in nursing homes licensed by the State and certified by the federal government to receive Medicare and Medicaid. Staff members conduct inspections and investigate complaints about health care facilities to track compliance with regulations, as well as providing consultation and training to encourage compliance and improve the quality of care.

Construction Section

This section reviews building plans and specifications for facilities seeking licensure or certification by DFS. The section also inspects physical plants and offers training for architects, engineers, and contractors involved in the construction of medical facilities.

Medical Care Commission

Composed of 17 members appointed by the Governor and supported by personnel from DFS, this commission establishes rules for regulating health care and related facilities, including nursing homes and home care agencies.

Acute and Home Care Section

This section is responsible for the oversight of hospitals, home care agencies, hospices, dialysis facilities, ambulatory surgery centers, and other

health care providers that must be licensed under State law and certified for participation in Medicare, and it investigates complaints about these facilities.

Adult Care Licensure Section

This section licenses all adult care homes and mental health facilities in the State. It coordinates oversight with adult homes specialists who work at county DSSs.

Mental Health Licensure and Certification Section

This section inspects and licenses psychiatric hospitals and psychiatric units of acute care hospitals, intermediate care facilities for mentally retarded (ICF/MR), and all other mental health group homes and treatment facilities.

Division of Medical Assistance

www.ncdhhs.gov/dma

The Division of Medical Assistance (DMA) oversees two programs: Medicaid and NC Health Choice for Children. North Carolina's Medicaid program serves approximately one out of every eight people residing in our State. Approximately $8.2 billion was spent during SFY 2005–08 on health services and premiums, amounting to $5,154 per recipient of all ages. While total service and premium expenditures increased by 10.3 percent, the increase per recipient was only 7.3 percent above SFY 2004–05 expenditures. Within the total increase, expenditures for services other than long-term care grew by 8.8 percent and long-term care expenditures grew by 13.7 percent. Recipients who are older or disabled comprised approximately 13 percent and 16 percent of total recipients, respectively; however, service expenditures for these two groups amounted to approximately $5.7 billion, or 70 percent of total Medicaid expenditures.

NC Medicaid covers a comprehensive array of preventive and treatment services for eligible enrollees. Preventive services include one annual physical for adults. Treatment services address virtually all acute and chronic illnesses. Medicaid has certain standard limitations on services. These include a limit on visits per year to practitioners, clinics, and outpatient departments. Prenatal services, dental services, and mental health services that are subject to independent utilization review are not subject to this limit. Exemptions from this limit also include services provided to recipients with end-stage renal disease; undergoing chemotherapy and/or radiation therapy for malignancies; with sickle cell disease; with hemophilia or other blood clotting disorders; under the age of 21; or enrolled in a Community Alternatives Program.

Medicaid recipients are limited to six prescriptions per month. However, recipients under age 21 and those enrolled in a Community Alternatives Program are not subject to this limitation. Recipients being treated for end-stage renal disease; malignancies requiring chemotherapy and/or radiation therapy; sickle cell disease; hemophilia or other blood clotting disorders; unstable diabetes; end-stage lung disease; other life-threatening illnesses; or who are in the terminal stage of any illness may be exempted from the dispensing limitation if it is deemed medically necessary by the recipient's primary prescribing physician.

Co-payments do not apply to recipients who are under age 21, who are enrolled in a Community Alternatives Program, or who are receiving services related to pregnancy or family planning services. Some services, procedures, and products also require prior approval to verify medical necessity or to ensure that the care that is received is appropriate and efficacious.

Mandatory Services

At a minimum, all state Medicaid programs must cover a core of health services. The following mandatory services are provided for Medicaid recipients in North Carolina.

Inpatient Hospital Services. Medicaid covers hospital inpatient services without a limitation on the length of stay. Selected inpatient procedures require pre-admission certification to ensure that the stay is medically necessary and that the procedure is most appropriately performed in an inpatient rather than an outpatient setting. Special restrictions apply to abortions, hysterectomies, and sterilization.

Hospital Outpatient Services. Outpatient services are covered subject to Medicaid's annual 24 physician-visit limitation, except for emergency room visits, which have no limits.

Other Laboratory and X-ray. Laboratory and X-ray services are covered when ordered by a physician. These services are covered in a variety of settings. Payment for these services is based on a statewide fee schedule.

Nursing Facility. All Medicaid recipients must receive prior approval before admission to a nursing facility. Prior approval is given only if recipients meet the State's medical criteria for admission. There is also a federal requirement for preadmission screening and annual resident review (PASARR) to screen and evaluate applicants and residents of Medicaid-certified nursing facilities for mental illness, mental retardation, developmental disabilities, and related conditions. In SFY 2005, a total of 38,693 Medicaid recipients over age 60 received care in nursing facilities at a cost of approximately $982,374,207.

Physician Services. Physician services are covered subject to an annual 24-visit limit. Selected surgical procedures require prior approval. A $3.00 co-payment is required for physician services except for certain exempt groups. Payment is made based on the lower of the physician's actual charges or the statewide Medicaid fee schedule amount.

Home Health Services. Home health services include medically necessary skilled nursing care, specialized therapies (physical therapy, occupational therapy, and speech therapy), home health aide services, and medical supplies needed for diagnosis, treatment or rehabilitation of a recipient's illness in the home setting when provided by a Medicare-certified home health agency. Services may be provided in the recipient's private residence or in an adult care home, except for home health aides. The services are considered part-time and intermittent and must be provided under a plan of care authorized by the patient's physician. In SFY 2005–06, a total of 82,094 Medicaid recipients over age 60 were served at a cost of $55,892,577.

Durable Medical Equipment. Durable medical equipment suitable for use in the home is reimbursed via a fee schedule.

Medical Transportation. The federal requirement for coverage of transportation for medical care services is met in three ways. (1) Medically necessary ambulance transportation is a covered benefit. (2) County departments of social services establish a local transportation network that may range from providing bus tokens to having county employees transport Medicaid recipients in county-owned vehicles. (3) Medicaid-eligible residents of nursing facilities and adult care facilities receive Medicaid-authorized transportation from the facilities in which they reside (other than medically necessary ambulance services).

Optional Services

Federal law permits states to cover additional services at their option. The following are optional services that North Carolina Medicaid covers:

Dental Services. NC Medicaid covers most diagnostic and preventive dental services such as exams, radiographs, dental cleanings, fluoride treatments, and sealants. Dental restorations, root canals, periodontal services, oral surgeries, and partial and full dentures are also covered. Most dental services do not require prior approval. Recipients 21 and older are charged a $3 copayment unless their coverage category is exempted.

Eye Care Services. The Optical Services Program is responsible for the overall administration of vision care services covered in the NC Medicaid Program. With prior approval, coverage includes eye exams and materials and services related to the provision of visual aids, including such things as corrective eyeglasses and medically necessary contact lenses. Prior approval is required for all visual aids. There are limitations regarding the frequency of eye examinations and the number of dispensed visual aids during specific eligibility periods. Eye examinations in excess of these limitations require prior approval. A $3 co-payment is applicable to ophthalmologic visits, while a $2 co-payment applies to visual aids. Although a $2 co-payment is generally required for new eyeglasses, eyeglass repairs and contact lenses, there are some exemptions.

Hospice, which is elected by the recipient, is a benefit package of medical and support services for terminally ill individuals. An individual is considered terminally ill if he or she has a medical prognosis of a six-month or less life expectancy as certified by a physician. The services include nursing care, medical social services, counseling, the professional care of a physician, in-home aide services, home management services, physical and occupational therapy, speech/language pathology, medical appliances and supplies, drugs and biologicals, and short-term inpatient care (general and respite) when related to the terminal illness. The services are provided in a private residence, an adult care home, a hospice residential care facility, or a hospice inpatient unit. The services also may be provided in a hospital or nursing facility under arrangement with the hospice agency. In SFY

2005, a total of 4,079 Medicaid recipients over age 60 were served at a cost of $40,346,516.

Intermediate Care Facilities for the Mentally Retarded (ICF-MR). These are long-term care facilities for people who have mentally retardation or developmental disabilities who meet certain federal criteria, including the need for active treatment for a severe, chronic disability. ICF-MR facilities must meet certification requirements relating to the provision of habitable services as well as basic intermediate care services. ICF-MRs are paid prospective per diem rates. During SFY 2005–06, a total of 439 recipients over age 60 were treated in ICF-MRs at a total cost of $48,751,201.

Personal Care Services. In-home Personal Care Services (PCS) provides aides to perform personal care tasks for people in private residences who need help with such basic personal activities as bathing, toileting and moving about, owing to a debilitating medical condition. Aides also monitor clients' vital signs. Services may also include housekeeping and home management tasks that are integral, although secondary, to the personal care tasks necessary for maintaining clients' basic personal health. PCS are based on a physician's authorized plan of care.

Eligible persons receive up to 60 hours of PCS per month, and some may qualify for an additional 20 hours if they meet more stringent eligibility criteria, through the PCS-Plus program. In SFY 2005–06, 31,572 Medicaid recipients over age 60 were served at a cost of $189,723,391.

Private Duty Nursing. Services are available for recipients who live in private residences and require substantial, complex, and continuous skilled nursing care as ordered by the attending physician. This service requires prior approval based on a physician's letter of medical necessity. In SFY 2005–06, a total of 371 (monthly average of 255) recipients of all ageswere served at an annual cost of $44 million.

Other Optional Services. These include clinical services, diagnostic testing, prescription drugs, mental health, chiropractor, podiatrist, physical and occupational therapy, speech/language pathology, home infusion therapy, case management, nurse anesthetist, preventive services, rehabilitative services, orthotic and prosthetic devices, screening, transportation, and HMO membership.

Special Community Alternatives Programs

DMA operates three programs to provide home and community care as a cost-effective alternative to institutionalization: CAP/DA for disabled adults, CAP-MR/DD for people with Mental Retardation/ Developmental Disabilities, and CAP/C for children. They are known as "waiver" programs because standard Medicaid program requirements are waived to allow the program to operate, and they provide some services that otherwise are not covered under Medicaid.

***Community Alternatives Program for Disabled Adults*.** The CAP/DA program provides services that allow adults (ages 18 and above) who require care in a nursing facility to remain in the community. By October 1996, all 100 of North Carolina's counties offered CAP/DA. Funding from the Kate B. Reynolds Charitable Trust through the Duke University Long Term Care Resources Program was instrumental in expanding CAP/DA statewide. In SFY 2005-06 11,438 Medicaid recipients over age 60 were served at the cost of $203,663,839.

Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities. The CAP-MR/DD program provides services to individuals of any age who normally would require care in an intermediate care facility for the mentally retarded. All 100 counties have access to the CAP-MR/DD program. In SFY 2005–06, 289 Medicaid recipients over age 60 were served at the cost of $11,454,036.

Other Medicaid Benefits Associated with Older People

Since February 1989, North Carolina has operated a program of health care financing assistance to older and disabled Medicare beneficiaries, as mandated by federal law. Depending on a person's income and resources the coverage may include (1) full Medicaid plan benefits, (2) payment of Medicare premiums, coinsurance, and deductibles, (3) payment of Medicare Part B premiums only, or (4) payment of a portion of the Medicare Part B premium.

Managed Care and Medicaid

Managed care options for Medicaid recipients, including Carolina ACCESS and Community Care of North Carolina, are available in all 100 North Carolina counties. Most, but not all, people eligible for Medicaid qualify for managed care. As of the end of SFY 2005–06, 791,240 of 1,053,366 people of all ages were eligible for this service and enrolled—about 75 percent.

Most Medicaid recipients in North Carolina are eligible to participate in a managed care plan. Although recipients of Medicaid who are dually eligible for Medicare and Medicaid are optionally enrolled in Carolina ACCESS, they are not enrolled in HMOs. Medicaid recipients who are in long-term care facilities are not enrolled in any managed care plan.

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

www.ncdhhs.gov/mhddsas

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) offers help and support to North Carolinians and their families suffering from mental illness, struggling with a drug or alcohol addiction, or coping with a developmental disability.

The division operates four regional psychiatric hospitals for people who need inpatient psychiatric services. It operates North Carolina Special Care Center in the eastern region for older people with serious medical and mental health conditions, which includes a unit for Alzheimer's patients. In the western region, the Black Mountain Center offers similar services, including respite for caregivers of people with Alzheimer's disease.
The division provides residential services of four regional developmental centers (Riddle, Caswell, O'Berry, and Murdoch Centers), which provide a wide range of services to people with severe and profound mental retardation and other related disabilities. The Black Mountain Center provides specialized residential services to people with developmental disabilities who are aging and have health care needs. The division also operates three centers that provide inpatient treatment for alcohol and drug abuse for adults.

The division is funding the development of 20 Geriatric/Adult Mental Health Specialty Teams, each consisting of at least a registered nurse and master's-level social worker both with expertise working with older individuals with mental illness. These teams will increase the capacity for communities to serve older adults who are discharged from the State psychiatric hospitals. The teams will provide technical support and training to the staff of nursing homes and adult care homes regarding behavioral issues related to mental illness.

Division of Public Health

www.ncpublichealth.com

The Division of Public Health (DPH) works to build healthy communities, promote healthful living, and reduce the risk and consequences of disease. Its primary role is to strengthen local health departments and to improve the health of the people. The division monitors public health achievements and performance and provides incentives and assistance to assure that no community falls below minimum standards. Further, the division is responsible for studying, coordinating, and enhancing health efforts involving or serving multiple communities and/or the State as a whole. Through education and public awareness programs, the division promotes public health, advocates physical fitness, improves the health of minorities, and advances good dental health. Through advocacy, education, policy, environmental, and systems change, as well as early detection, the division fights chronic diseases such as cancer, heart disease, asthma and diabetes. The division itself is a provider of statewide health services not otherwise available. For migrants and refugees, it provides access to essential preventive and primary health care while they reside in North Carolina.

The division's Chronic Disease and Injury Section is committed to integrating initiatives to improve the health of older adults across its branches, including those focusing on heart disease and stroke, diabetes, asthma, cancer, physical activity, and nutrition. Overall goals are to help (1) ensure that communities are healthy places

in which to live, (2) extend the span of healthy life, (3) assure access to quality health care services, and (4) eliminate health disparities in given demographics. This section works with the North Carolina Division of Aging and Adult Services, UNC's Institute on Aging, and a variety of other agencies and organizations on various programs designed to address the older adult population.

One example of such a collaboration is the North Carolina Arthritis Program, funded through a cooperative agreement between DPH and the Centers for Disease Control and Prevention (CDC), whose goal is to prevent disability and improve the quality of life for the 2.4 million North Carolina adults who live with arthritis and other rheumatic conditions.) The program is guided by the NC Arthritis Advisory Board whose members are drawn from such organizations as the Arthritis Foundation Carolinas Chapter, UNC Institute on Aging (IOA), AARP NC, DAAS, NC Office on Disability and Health, and others. The program, in collaboration with its board, has finalized the North Carolina Arthritis Plan: 2007–2010, which sets measurable objectives for statewide efforts to (1) increase participation in arthritis interventions, (2) raise awareness of physical activity as a way to manage arthritis, and (3) create and maintain federal, state, and local policies and environments supportive of arthritis management in North Carolina.

Another important effort is the Senior Grant, funded by the Chronic Disease Director's Association, for a partnership among the division, DAAS, and the Institute on Aging to develop a North Carolina Roadmap for Healthy Aging by 2008. It will promote a more coordinated and systemic effort between the two divisions and with other partners in the North Carolina Healthy Aging Coalition through an interdivisional healthy aging team that will (1) analyze existing surveillance and survey data, and collect more about health conditions and risks of older adults; (2) map and assess resources and opportunities within each service network to conduct healthy aging programming; and (3) develop and disseminate a Roadmap that includes priorities for programs and populations and outlines strategies for implementation.

Division of Services for the Blind

www.ncdhhs.gov/dsb

The Division of Services for the Blind (DSB) promotes the prevention of blindness through education and vision screenings. Funding for some eye-related treatment is available to assist people with very low incomes and no other financial means for obtaining the required treatment. Additionally, the agency provides the specialized services that assist people who are blind and visually impaired to live independently in their homes and communities and obtain or retain employment if they wish. Examples of specialized services include Braille instruction, safe travel skills training, and use of adaptive technology such as speech or large print output for computers. Many low-tech and high-tech devices are available to assist blind and visually impaired people in the home, school, and work environments. Services are available in all counties to people of all ages.

The division has a special program designed to meet the needs of people 55 and older who lose vision. The DSB Independent Living Older Blind Program offers an array of services that include counseling and guidance; information and referral; individual and systems advocacy; and instruction in adaptive skills for daily living including personal and home management, safe travel, and adaptive aids and technology. The program uses the expertise of independent living rehabilitation counselors, orientation and mobility specialists, contractual teachers, and nurse eye care consultants to provide a variety of services to help consumers reach their rehabilitation goals. Services can be provided in consumers' homes or in small group settings in their communities called "Mini Centers." The division also administers Special Assistance payments for blind and visually impaired residents of adult care homes.

Division of Services for the Deaf and the Hard of Hearing

www.ncdhhs.gov/dsdhh

The Division of Services for the Deaf and the Hard of Hearing (DSDHH) provides information and assistance to the approximately 1,000,000 North Carolina residents—363,000 of whom are 65 years of age or older—who are deaf, hard of hearing, or deaf-blind. The division has seven statewide regional offices that provide a broad range of services for people of all ages who have hearing loss, their families, communities, and the professionals who serve them. These services include, but are not limited to, advocacy, information and referral, counseling, access to and education about technology, Telecommunications Equipment Distribution (TED) that includes hearing aids, telephones, and alerting devices, an Emergency Awareness Program with weather radio distribution, Telecommunication Relay Service, CapTel, and community education and outreach.

Division of Social Services

www.ncdhhs.gov/dss

The Division of Social Services, working with county departments of social services (DSSs), strives to ensure that every family and individual has sufficient economic resources to obtain the basic necessities of life. Consistent with this objective, the division administers two programs vital to the economic security of seniors with low incomes.

Food Stamp Program. This federal entitlement program provides a monthly allotment of Food Stamp benefits, issued by Electronic Benefit Transfer cards to eligible individuals and households. Many counties are conducting outreach activities to reach unserved older adults in the community. A six-year demonstration project targeting senior Supplemental Security Income (SSI) recipients age 65 or older was implemented in August 2005, the Simplified Nutritional Assistance Program (SNAP). It features a one-page application mailed to individuals who may be eligible. Benefits are based on the household's shelter expenses, and cases are certified for three years. There are currently over 19,500 seniors benefiting from SNAP.

Low Income Energy Assistance Program. LIEAP provides a one-time cash payment to help eligible families pay their heating bills. This payment is mailed in February of each year.

Division of Vocational Rehabilitation Services

www.ncdhhs.gov/dvr

The Division of Vocational Rehabilitation Services (DVR) includes three major programs, Vocational Rehabilitation (VR), Independent Living Rehabilitation (IL), and the North Carolina Assistive Technology Program (NCATP), whose goals are to promote employment and independence for persons with disabilities through customer partnerships and community leadership.

Vocational Rehabilitation. For persons with physical or mental disabilities, VR focuses on training and work-related services to help overcome obstacles that prevent people with disabilities from getting or keeping a job. VR services are provided by an outreach effort through 31 offices statewide, 2 facilities, and numerous satellite locations.

Independent Living Rehabilitation Services. These services help people identify viable alternatives to institutionalization and support independent living. When possible, consumers maintain independence through transition to VR Services. IL services are provided through 16 offices statewide, many of which are collocated with VR offices. Both services often use community partners and resource coordination in jointly developed service plans to assist consumers in achieving their goals, whether employment using VR services, or independent living through IL, where a work goal is not required.

Among the services available are job training and seeking skills, job placement, supported employment, and job and worksite modifications through VR. Both services can assist with vehicle and home modifications, adaptive aids, and rehabilitation engineering to meet consumers' goals.

North Carolina Assistive Technology Program. Created under the Assistive Technology Act 2004 (P. L.108-364), NCATP is a state- and federally-funded program to increase access to assistive technology for people of all ages and abilities.

Office of Citizen Services

www.ncdhhs.gov/ocs

The Office of Citizen Services (OCS) guides citizens through the human services delivery system. Its mission is accomplished through its Ombudsman Program and through the CARE-LINE/Information and Referral Service. The Ombudsman Program serves as the liaison between citizens and the Department of Health and Human Services and handles inquiries and complaints about the department. The CARE-LINE information and referral specialists provide information and referral on human services in government and nonprofit agencies, drawing on a database of over 11,000 agencies. Both programs may be accessed by calling 919-855-4400, or toll-free 1-800-662-7030 (voice/Spanish). The office is equipped with a dedicated TTY phone number, 919-733-4851, or toll-free 1-877-452-2514. On average, the office handles over 80,000 inquiries a year.

Office of Economic Opportunity

www.ncdhhs.gov/oeo

The Office of Economic Opportunity (OEO) channels funds primarily to community-based, private nonprofit agencies for activities under the Community Services Block Grant Program, the Emergency Shelter Grants Program, and the Weatherization Assistance Program. The federally-funded Community Services Block Grant Program helps communities address the causes and conditions of poverty by helping people become self-sufficient, gain employment, and find long-term housing. The Emergency Shelter Grants Program helps communities serve homeless individuals and families. Reduction in residential energy consumption and costs is the focus of the Weatherization Assistance Program. The State's 36 Community Action Agencies and the other private, nonprofit agencies that receive grants through OEO, generate, on average, $10 for every $1 provided by OEO.

Office of Long Term Services and Supports

Within the Office of the Secretary of the Department of Health and Human Services (DHHS) is the Office of Long Term Services and Supports (OLTS), headed by the Assistant Secretary for Long Term Care and Family Services. Established as recommended in the 2001 report of the Institute of Medicine's Task Force on Long Term Care, the mission of this office is to assure coordination in DHHS's efforts to reform long-term services and supports (LTS). Through reorganization of existing positions and the procurement of federal grants, the office has developed a core group of professionals to lead interdivisional activities in such areas as transportation, consumer-directed care, housing, direct care workforce development, and LTS systems transformation.

Eight divisions share responsibilities for various aspects of the regulation, development, and funding of long-term care services for older adults and individuals with disabilities. The DHHS Secretary also established a Long-Term Services and Supports Cabinet, composed of the directors of these divisions and chaired by the Assistant Secretary for Long Term Care and Family Services. The Cabinet provides a vehicle for interdivisional LTS planning, leadership, policy and data analysis, research and evaluation, development and coordination of services training, and public communication. Based on the institute's recommendations, OLTS has developed a work plan for the collaborating State divisions. In addition, the Office and Cabinet coordinate North Carolina's planning to accord with the Olmstead decision.

The OLTS has moved forward to implement many of the Institute of Medicine's recommendations because of its success in securing multiple federal grants from the Centers for Medicare and Medicaid Services. In 2006 OLTS received a Systems Transformation grant totaling $2.3 million for five years, which it will use to improve access to long-term services, increase consumer control and choice, and transform information technology to support systems change.

Office of Rural Health and Community Care

www.ncdhhs.gov/docs/divinfo/orhrd.htm

The Office of Rural Health and Community Care provides technical assistance to small hospitals and community health centers in rural and medically underserved communities. The office also recruits health care providers to work in these communities and provides grants for community health centers.

This office is the lead agency for demonstrations in the delivery and financing of health care for DHHS. Presently they are working on a Medicaid program called Access II & III, and an indigent care and chronic care demonstration.

Additionally, the office also administers NCRx, a prescription drug assistance plan to help seniors with low incomes who meet eligibility requirements participate in the federal Medicare Part D prescription drug program. The program will pay up to $18 toward monthly premiums for Medicare prescription drug plans that work with NCRx.

DEPARTMENT OF ADMINISTRATION

www.doa.state.nc.us

Commission of Indian Affairs

The Commission of Indian Affairs administers the Community Services Program that provides in-home aide services and/or volunteer transportation for older and disabled people in Bladen, Columbus, Halifax, Warren, Cumberland, Sampson, and Harnett counties. The program also provides oversight to a meal program for older and physically challenged Indian senior citizens residing in Sampson County. The Community Services Program director coordinates an annual North Carolina Indian Senior Citizens Conference, sponsored by the North Carolina Indian Senior Citizens Coalition.

Council for Women/NC Domestic Violence Commission

The North Carolina Council for Women is the official State advocacy agency for women. Its mission is to advise the Governor, the legislature, and the principal State departments on the special needs of women in North Carolina. It also develops and administers programs of special relevance to women. Two such programs of particular value to older women are the Displaced Homemakers Program, which helps women returning to the work force after many years of unpaid employment, and the Domestic Violence Program.

Division of Veterans Affairs

The Division of Veterans Affairs assists veterans and their families in the presentation, processing, proof, and establishment of claims, privileges, rights, and benefits as they may be entitled to under federal, state, or local laws. The division also cooperates with the various governmental units and veterans' organizations in seeking to serve veterans. Its work is meant to supplement and augment the efforts of others. As an example of this, the division constructed the State's first nursing facility for veterans with support from the NC General Assembly and the US Department of Veterans Affairs. This 150-bed State veterans' home, located in Fayetteville near the VA Medical Center, started admitting residents in 1999.

THE DEPARTMENT OF COMMERCE

www.nccommerce.com

Employment Security Commission

www.ncesc.com

The mission of the Employment Security Commission (ESC) is to promote and sustain the economic well being of North Carolinians in the world marketplace by providing high quality and accessible workforce-related services. The ESC provides employment services, unemployment insurance, and labor market information to the State's workers, employers, and the public. These services promote economic stability and growth, development of a skilled workforce, and a world class economy for North Carolina. ESC registered and served 67,238 applicants over age 55 during SFY 2005–06.

THE DEPARTMENT OF CORRECTION

www.doc.state.nc.us

About 43 percent of the State's prison population as of February 2002 were boomers or older. One result of the aging of the prison population is the increasing demand for health care. An example of the Department of Correction's response is the 54-bed health ward for male inmates with special needs at the Randolph Correctional Center, whose unique population includes inmates who are in wheelchairs, some who have cancer, and others who have multiple heart problems. The prison psychologists started an anger–stress management program for inmates 65 years and older, many of whom are veterans who were heavy alcohol or substance abusers. A large number of the older inmates are in prison on their first offense. Many have no family, or their children may be aging and unable to visit because of medical problems of their own. Especially because of the needs of its prison population, this center values community volunteers.

THE DEPARTMENT OF INSURANCE

www.ncdoi.com

Seniors' Health Insurance Information Program (SHIIP) – www.ncshiip.com
The Seniors' Health Insurance Information Program, known as SHIIP, was established in 1986 by North Carolina Insurance Commissioner Jim Long in response to an increased number of calls, letters, and complaints from older North Carolinians confused by their health insurance options. SHIIP's primary objective is to educate the public on seniors' health insurance, concentrating on Medicare, Medicare supplements, Medicare Advantage, Medicare Part D, and long-term care insurance. SHIIP achieves this by training volunteer counselors in all 100 counties, by operating a toll-free hotline from the State SHIIP office (1-800-443-9354), and by developing educational materials for use by consumers.

SHIIP creates a number of consumer publications on a yearly basis. It serves as a clearinghouse for many publications of the Centers for Medicare & Medicaid Services. It has served as the State's primary resource for educating Medicare beneficiaries about Medicare Part D and the other recent Medicare changes.

SHIIP is coordinated in each county through an existing human service agency such as an area agency on aging, council or department on aging office, a senior center, or a cooperative extension office. These agencies serve as sponsors that provide important continuity, an available point of access, and model interagency cooperation.

Continuing Care Facilities Section
Continuing Care Retirement Communities (CCRCs) provide a living alternative for retirement-aged people. The Continuing Care Facilities Section provides the financial oversight and licensing of continuing care facilities, as well as additional safeguards for facility residents and prospective residents. This authority applies only to facilities that furnish lodging or independent living together with health-related services under a contract for the life of the individual or for a period in excess of one year. Current laws provide for facility disclosure of all material facts and financial data; departmental authority to intervene in the event of insolvency or the imminent danger of financial impairment; departmental authority to audit the books and records of facilities; and the establishment of a nine-member advisory committee to advise the Insurance Commissioner.

THE DEPARTMENT OF JUSTICE

www.ncdoj.gov

Attorney General's Office

The Attorney General's office was a founder of the North Carolina Senior Consumer Fraud Task Force, and the office continues to be responsible for issuing electronic fraud alerts. The office also participates in free consumer education seminars around the State.

Consumer Protection Division. This division works to protect the public from unfair and deceptive business practices. Common complaints involving seniors include home repair, annuity sales, telemarketing, sweepstakes, foreign lotteries, work at home, and predatory mortgage lending. Victims of a fraud or scam can seek help from Consumer Protection by calling 1-877-5 NO SCAM (877-566-7226). Consumer Protection also assists consumers on utility, antitrust, and health insurance issues.

Victims and Citizens Services. Victims and Citizens Services section promotes crime prevention programs around the State and connects citizens with community resources. Subjects of interest to seniors include scams and frauds, financial exploitation, elder abuse, identity theft, open government, victims' rights, and confidentiality.

THE DEPARTMENT OF TRANSPORTATION

www.ncdot.org

Our national reputation as the "good roads state" stems from NC's large state highway system—the second largest in the country. There are over 6 million licensed drivers in the State, 20 percent of whom are age 60 and older. Increasingly NCDOT's traffic engineers are applying federal guidelines for accommodating older drivers and pedestrians, as crash statistics and other analysis help to determine the factors that make crash locations hazardous for older drivers.

The Division of Motor Vehicles (DMV)

www.ncdot.org/dmv

DMV operates a Driver Medical Evaluation program to determine whether to grant or renew drivers' licenses when medical conditions affect a person's ability to operate a vehicle safely. Referrals to the program come from DMV license examiners, as well as family members, physicians, law enforcement officers, and the courts. The number of referrals has been rising. On average, DMV reviews 47,000 cases a year. Figures from 2006 indicated that only about 20 percent of the drivers who were evaluated had their licenses cancelled for medical reasons. Of the rest, about 30 percent were required to provide additional information, 45 percent were allowed to continue driving, and 5 percent were removed from the program. In 2006 there were 173,607 drivers in the DMV medical evaluation program. The division can impose restrictions on licenses, a policy that works to the advantage of people when the alternative is loss of license and independence. Corrective lenses for drivers with impaired vision are by far the most common restrictions. Other examples of restrictions that can make the difference between having or not having a license include daylight driving only, 45 mph/no interstate driving, no driving beyond a certain radius from home, and use of pedal extensions.

The department established an Executive Committee for Highway Safety in 2003 and has since formed a large number of working groups around specific safety issues. In 2005 an Older Driver Safety Working Group was formed to recommend strategies for reducing crashes involving older drivers and pedestrians.

When older drivers are no longer able to fulfill all their transportation needs with their own vehicles, they seek alternative ways of getting around. There are 105 systems providing transportation services in all 100 NC counties: 21 urban or small urban transit systems, 2 regional urban systems, 71 single-county community transportation systems, 7 regional community transportation systems, and 4 systems that provide human service transportation only. Operating statistics for these systems indicate that more than 50.5 million rides are provided each year with a combination of federal, state, local, and fare-based funding.

THE OFFICE OF THE GOVERNOR

www.governor.state.nc.us

NC Commission on Volunteerism and Community Service

www.volunteernc.org

AmeriCorps is a yearlong commitment for men and women age 18 and older from all backgrounds who commit themselves to building communities. Across the State, AmeriCorps members tutor and mentor school-age youth, work with preschool children in childcare centers, build houses for homeowners with low income, protect the environment, and provide new North Carolinians with interpretation and translation services. Full-time, part-time, and minimum-time positions are available. Members are paid a small living allowance. Members also receive an educational award at the conclusion of their service, which can pay for college, professional school, or student loans. Full-time members are also eligible for health care benefits and childcare coverage.

Citizen Corps coordinates volunteers to help make our communities better prepared to respond to emergencies. Currently, there are 87 local county and municipal Citizen Corps Councils serving 72 percent of the State's population. Citizen Corps is composed of four programs:

- *The Community Emergency Response Team (CERT)* program trains people to be prepared to respond to emergencies by supporting first responders, providing immediate assistance to victims, and organizing spontaneous volunteers at a disaster site.

- *Neighborhood Watch* programs recruit neighborhood residents to look out for suspicious activity and to report it to law enforcement and to each other.

- The *Volunteers in Police Service (VIPS)* program recruits civilian volunteers to help law enforcement professionals better perform their frontline duties by incorporating them into the activities of the law enforcement agency—using a series of best practices to help state and local law enforcement design strategies to recruit, train, and use citizen volunteers in their departments.

- The *Medical Reserve Corps (MRC)* program asks practicing and retired physicians, nurses, and other health professionals, as well as citizens interested in health issues, to volunteer to address their community's ongoing public health needs and help their community during large-scale emergency situations.

NC Mentoring Partnership. A mentor is an adult who provides young people with support, counsel, friendship, reinforcement, and constructive example. Mentors work with students at a variety of places including schools, churches, and organizations. A list of mentoring programs by county is available on the Commission's website.

NC Volunteer Awards. The NC Award for Outstanding Volunteer Service is a statewide program that honors the spirit of volunteerism by recognizing individuals, groups, teams, and businesses that make a significant contribution to their community through outstanding volunteer service. County coordinators and local selection committees receive and evaluate the nominations. A new award was added to this program in 2006. The NC Medallion for Outstanding Volunteer Service is designed to recognize 20 of the top volunteers in the State. Counties nominate one volunteer whose service is evaluated by a panel of community service leaders from across the State.

NORTH CAROLINA HOUSING FINANCE AGENCY

www.nchfa.com

The North Carolina Housing Finance Agency operates a variety of programs to finance home ownership for first-time homebuyers with low or moderate incomes, provide affordable rental housing for renters with low or moderate incomes, and rehabilitate substandard owner-occupied and rental housing. Funding for agency programs and operations comes from program fees, earnings from tax-exempt bond sales, federal funds, and the North Carolina Housing Trust Fund.

HIGHER AND CONTINUING EDUCATION RELATED TO AGING

North Carolina's colleges and universities have distinguished themselves in the field of aging through their research; interdisciplinary professional and postgraduate programs; undergraduate degree programs; community-oriented service and technical assistance activities; and their clinical programs in medicine, dentistry, pharmacy, nursing, social work, and other disciplines. Institutions of higher education in our State also offer continuing education programs for older people and those who work with people in this age group. Some of these institutions have opened their doors to provide special programs offering access to resources and lifelong learning opportunities for older adults in our State.

Area Health Education Centers Program (AHEC)

www.med.unc.edu/ahec

The AHEC program seeks to improve the supply, distribution, and quality of health care professionals in North Carolina through its ten regional centers. AHEC works with the State's four university medical centers to sponsor a wide range of educational activities related to health manpower development, including community training for health science students, medical residency training programs in primary care, continuing education, and information services. AHEC was created in 1972 by the School of Medicine at UNC-Chapel Hill and funded with a federal grant. In 1974, the General Assembly expanded the AHEC program and took over its funding. Today the program is funded about equally from state and local sources and is administered by the Dean of the UNC-Chapel Hill School of Medicine. Program activities fall into three broad categories: community-based and medical residents; health professions continuing education; and information services for health care agencies and professionals. An example program is the Geriatric Medicine Program at the Mountain Area Health Education Center (MAHEC) located in Asheville. MAHEC is a partner with UNC-Asheville and Western Carolina University in the development of the State supported North Carolina Center for Health and Aging. This Center's mission is to identify and promote healthy lifestyles and successful aging among all population groups.

THE NORTH CAROLINA COMMUNITY COLLEGE SYSTEM (NCCCS)

www.nccommunitycolleges.edu

Human Services Technologies Programs

Through these programs, NC Community Colleges prepare students for entry-level positions in institutions and agencies that provide social, community, and educational services. Along with core courses, students take courses that prepare them for specialization in specific human areas including developmental disabilities, gerontology, mental health, social services, and substance abuse. Graduates seek employment in mental health, child care, family services, social services, rehabilitation, correctional, and educational agencies. Graduates work with children, older adults, people with disabilities, families, groups, organizations, and communities in providing care.

North Carolina Literacy Resource Center

NCLRC fosters networking among organizations concerned with basic skills and education for adults, assists North Carolina's literacy community in providing quality services to adults in the State, and serves as a link between the National Institute for Literacy and North Carolina's literacy community. Two of the center's initiatives include participation in Equipped for the Future, the National Institute for Literacy's system reform initiative, and the encouragement of local basic skills/literacy programs to access the Internet, establish home pages on the World Wide Web, and use Internet-based resources in designing lessons. Literacy and basic skills development are both areas of concern for a number of seniors.

NORTH CAROLINA COOPERATIVE EXTENSION SERVICE

www.ces.ncsu.edu

The North Carolina Cooperative Extension Service is an educational organization supported by federal, state, and county funds. It serves 100 North Carolina counties and the Cherokee Reservation. Extension agents, serving as field faculty of land grant universities, deliver research-based informal educational programs addressing the priority concerns selected by each county's advisory system. Extension Specialists at North Carolina State University and North Carolina A & T University develop educational materials as well as train and support the county agents. The Extension Service offers a wide range of educational programs and resources on aging issues. One statewide program called Aging with Gusto! is designed to give adults research-based information to help them plan for and get the most out of their later years. Specific programs are available on such topics as caregiving, developing positive attitudes, home modification, retirement planning, estate planning, and nutrition and wellness in later life.

UNC INSTITUTE ON AGING

www.aging.unc.edu

The UNC Institute on Aging (IOA) was created by the NC General Assembly in 1996. IOA's mission is to enhance the well-being of older North Carolinians through statewide collaboration in research, education, and public service. IOA works through its statewide linkages to promote collaborative, applied and basic gerontological research, develop innovative programs of interdisciplinary education and practice, and provide state-of-the-art information to policy makers, program managers, service providers, clinicians, and the general public.

Examples of IOA activities include conducting research projects on pertinent aging issues such as workforce development in long term care, older workers' retirement, the life course of librarians, and civic engagement of older adults; coordinating the annual North Carolina Conference on Aging and Aging Boot camps for new aging services workers; administering and supporting the activities of the North Carolina Healthy Aging Coalition; hosting a Distinguished Lecture series on aging; participating in the North Carolina and National Healthy Aging Network; collecting and providing access to aging-related resources through an extensive digital library; providing pre- and post-doctoral training on aging and health issues; and sponsoring the UNC Senior Leadership Initiative. The IOA's Center for Aging and Diversity conducts research on Alzheimer's disease, caregiving in African American and Native American populations, and minority aging. Many of the colleges and universities affiliated with the UNC Institute on Aging have substantial educational, research, and community services activities in aging. Examples include the North Carolina Center for Creative Retirement at UNC-Asheville, the gerontology programs at UNC-Greensboro, UNC-Charlotte, Appalachian State University, East Carolina University, UNC-Pembroke, UNC-Wilmington, Western Carolina University, Elizabeth City State University, and Winston-Salem State University.

NORTH CAROLINA SENIOR GAMES

www.ncseniorgames.org

North Carolina Senior Games is a statewide, year-round health promotion and education program for people age 55 and "better." This wellness and prevention program focuses on keeping seniors healthy and independent and involved in personal fitness. There are 52 local Senior Games that serve the entire State. In addition to the games, the organization offers SilverArts, a literary, heritage, visual, and performing arts program; SilverLiners, a senior line-dancing association; SilverStriders, a national award-winning walking program; statewide workshops; leadership training for professionals; educational material such as exercise posters; and health information. North Carolina Senior Games is supported by the State, several corporate sponsors, and many coordinating and endorsing agencies such as the Division of Aging and Adult Services, Division of Public Health, Parks and Recreation, AARP NC, and the medical profession.

Other Programs

Corporation for National and Community Service (State Office) www.nationalservice.gov
(also see NC Commission on Volunteerism and Community Service)

Retired and Senior Volunteer Program. (RSVP) As part of the Corporation for National and Community Service, RSVP helps people age 55 and older find service opportunities in their home communities. RSVP has minimal paid staff and provides the following benefits to its volunteers: insurance, meal and mileage reimbursement, and recognition. There is no per diem or wage paid to participant volunteers.

Senior Companion Program. This is a service initiative through which people age 60 and older provide assistance and friendship to older adults who are homebound and, generally, live alone. Senior Companions receive a modest hourly stipend for their service. They usually serve two to four clients through 20 hours of weekly service.

Foster Grandparent Program. (FGP) This program offers people age 60 and older opportunities to serve as mentors, tutors, and caregivers for children and youth with special needs. They provide 20 hours of weekly service to community organizations such as schools, hospitals, and youth centers.

Appendix B: Area Agencies on Aging (AAA)

REGIONAL AAAs and CONTACT INFORMATION

(as of February 2007)

REGION	COUNTIES SERVED	AREA AGENCY ON AGING	DIRECTOR/PHONE
A	Cherokee, Clay, Graham, Haywood, Jackson, Macon, Swain	Southwestern Commission 125 Bonnie Lane Sylva, NC 28779 www.regiona.org	Mary Barker 828-586-1962 x216
B	Buncombe, Henderson, Madison, Transylvania	Land-of-Sky Regional Council 25 Heritage Drive Asheville, NC 28806 www.landofsky.org	Joe Connolly 828-251-6622 x119
C	Cleveland, McDowell, Polk, Rutherford	Isothermal Planning & Development Commission P.O. Box 841 Rutherfordton, NC 28139 www.regionc.org	Laura Lynch 828-287-2281 x1232
D	Alleghany, Ashe, Avery, Mitchell, Watauga, Wilkes, Yancey	High Country Council of Governments P.O. Box 1820 Boone, NC 28607 www.regiond.org	Anita Davie 828-265-5434 x122
E	Alexander, Burke, Caldwell, Catawba	Western Piedmont Council of Governments P.O. Box 9026 Hickory, NC 28603 www.wpcog.org	Sheila Weeks 828-322-9191 x212 828-485-4212 (direct)
F	Anson, Cabarrus, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, Union	Centralina Council of Governments P.O. Box 35008 Charlotte, NC 28235 704-372-2416 (COG) www.centralina.org	Gayla Woody 704-348-2727
G	Alamance, Caswell, Davidson, Guilford, Montgomery, Randolph, Rockingham	Piedmont Triad Council of Governments Koger Center 2216 W. Meadowview Road, Suite 201 Greensboro, NC 27407-3480 www.ptcog.org	Kimberly Dawkins Berry 336-294-4950 x325
I	Davie, Forsyth, Stokes, Surry, Yadkin	Northwest Piedmont Council of Governments 400 West Fourth St., Suite 400 Winston Salem, NC 27101 www.nwpcog.org	Dean Burgess 336-761-2111 x116

REGION	COUNTIES SERVED	AREA AGENCY ON AGING	DIRECTOR/PHONE
J	Chatham, Durham, Johnston, Lee, Moore, Orange, Wake	Triangle J Council of Governments P.O. Box 12276 Research Triangle Park, NC 27709 www.tjaaa.org	Joan Pellettier 919-558-9398
K	Franklin, Granville, Person, Vance, Warren,	Kerr Tar Regional Council of Governments P.O. Box 709 Henderson, NC 27536 www.kerrtarcog.org	Steve Norwood 252-436-2052
L	Edgecombe, Halifax, Nash, Northampton, Wilson	Upper Coastal Plain Council of Governments P.O. Drawer 2748 Rocky Mount, NC 27802 www.ucpcog.org	Heather Proctor 252-446-0411 x235
M	Cumberland, Harnett, Sampson	Mid-Carolina Council of Governments P.O. Drawer 1510 Fayetteville, NC 28302 www.mccog.org	Carolyn Tracy 910-323-4191 x26
N	Bladen, Hoke, Richmond, Robeson, Scotland	Lumber River Council of Governments 4721 Fayetteville Road Lumberton, NC 28358 www.lrcog.dst.nc.us	Margaret Kelly 910-618-5533 x3034
O	Brunswick, Columbus, Hanover, Pender	Cape Fear Council of Governments 1480 Harbour Drive Wilmington, NC 28401 1-800-218-6575 www.capefearcog.org	Jane Jones 910-395-4553 x209
P	Carteret, Craven, Duplin, Greene, Jones, Lenoir, Onslow, Pamlico, Wayne	Eastern Carolina Council of Governments 233 Middle Street P.O. Box 1717 New Bern, NC 28563 1-800-824-4648 www.eccog.org	Tonya Cedars 252-638-3185 x3009
Q	Beaufort, Bertie, Hertford, Martin, Pitt	Mid-East Commission 1385 John Small Avenue P. O. Box 1787 Washington, NC 27889 www.mideastcom.org	Cynthia Davis 252-974-1835
R	Camden, Chowan, Currituck, Dare, Gates, Hyde, Pasquotank, Perquimans, Tyrrell, Washington	Albemarle Commission P.O. Box 646 Hertford, NC 27944	Susan Scurria 252-426-5753 x224

Appendix C: Emerging Issues

(as stated in Area Plans of the 17 Area Agencies on Aging)

PHYSICAL AND ACCESSIBLE ENVIRONMENT

Transportation

- Rural areas a problem
- Need more than mountain mobility
- Need special vans
- Tennessee border residents want to go to Tennessee
- County provides limited transportation for seniors
- No public transportation
- Lack of affordable transportation
- Public transit system available in one of four counties (Region O)
- No public transportation available in any counties in Region R
- Funding for available transportation is not adequate to meet community needs due to distance between local communities and necessary medical facilities and services
- Hard to fix issues with rural community
- Operating budget for transit system in Region E is flat even as the demand for service increases
- Many older adults depend on area transit system for transportation to dialysis and other medical appointments
- Lack of availability of public transportation
- Transportation noted as the highest concern among members of the advisory council of aging in Region J
- Transportation cost, utilization, and availability is a major concern in Durham county
- Bus routes are limited
- Ambulances are being used inappropriately for non-emergency transportation
- Support efforts to develop a coordinated transportation system
- Transportation services do not have adequate funding to meet community needs, need to operate more days of week and longer hours each day
- Transportation is limited to rural areas
- Need better public transportation
- Shortage of public transportation
- Service providers of transportation cannot provide services because of budget concerns and waiting lists

Air/water quality

- Government funding curtailment major factor towards good health
- Limited outdoor
- No indoor quality regulations
- EPA report on air pollution
- Lots of people with asthma
- Region P in violation of the new, more stringent USEPA standards for air quality
- Ground level ozone levels can adversely affect older adults with respiratory disease
- Older adults need to be educated on how they can protect their health by taking recommended actions to improving air quality in their homes
- Water quality and future availability is an ongoing issue for communities in Region P
- Improve regional air quality
- Areas can lose government funding because of air pollution
- Older adults suffer from breathing/asthma/ allergy conditions
- Air quality and water quality affect all people, but seniors are often affected to a greater degree because of another chronic condition that aggravates it

Housing utilities

- Need low income housing
- Affordable housing
- Should we mix older/younger folks
- Many low income elderly live in substandard housing
- Emergencies in home repair
- Lack of housing
- Insufficient amount of subsidized housing for elderly/disabled in all counties
- Waitlists no longer utilized due to overwhelming demand in two of four counties
- Substandard housing exists in all counties
- Few programs available for affordable rehabilitation
- Unsafe living conditions for many seniors due to lack of affordable rehabilitation
- Lack of "universal design" homebuilders due to increased cost associated with such a design
- Stricter mandates in mountain housing
- Not enough housing options for low income seniors
- Large waiting list for Section 8 housing assistance in all four counties (Region E)
- Low income housing opportunities for people not eligible through housing authorities due to criminal backgrounds or waiting lists
- Lack of affordable housing an issue in all Region J counties
- Affordable senior housing is very limited. It is hard to find and often in unsafe areas
- Offer door-to-door "handyman" transportation service

- Implement a "handyman" service using volunteer groups and organizations to help seniors make home repairs
- There needs to be more thought and planning for senior housing
- There should be housing available to people (and senior adults) who have a pet. Pets help senior adults deal with loneliness and pets are therapeutic for good health
- Needs to be more affordable housing for seniors
- Shortage of affordable homes
- Building contractors need to be approached from interest groups that provide services to seniors to advocate for them to build affordable dwellings for seniors
- There is no independent housing with services available
- Even though there is some home repair available for low income, there are not folks who are honest that can be hired at a reasonable rate for those who can afford to pay
- Housing for a significant number of elderly is unsafe, in need of major repair, and/or lacks adequate plumbing
- Although much has been done to provide affordable housing for seniors, there is still significant need
- Existing housing unites for seniors need renovation and many elderly residents need assistance with home repairs

Land use

- Poor current land use
- Zoning
- Support county's land use plan which promotes more greenways and open areas

Neighborhood organizations

- Community organizations work for the betterment of the community
- Need senior centers
- Increase use and availability of senior centers
- Neighborhood associations could be better utilized in providing support to older adults in Durham county
- Senior adults can become homebound if they can't get out to attend a Senior Center, go to a doctor/dentist, or to a nutrition site or even shopping

Noise control (no issues submitted)

Road safety

- Highway safety & road repairs have not kept up with area growth
- Promote senior driving skills
- Placement and size of street signs can make driving difficult and at times unsafe for seniors
- Driving on the main highway is daunting for senior adults
- Need better alternate routes
- Better and easier to read signs for streets and road reflectors
- Many seniors can no longer drive their own vehicles
- Traffic congestion and lack of alternative paths around busy congested areas
- Unsafe conditions for citizens and older adults with visual impairments
- Size of signage and multiple signs in one location can create unsafe driving conditions for seniors due to visual and other impairments

Recreational facilities

- Senior centers good but do not do enough
- Senior centers need to offer more
- Need to ask elders' interests
- Senior centers low on meeting needs
- Need to mix range of people
- Lack of recreational facilities
- Parks and activities for seniors
- Promote and enhance community fitness trails

Shopping

- Increase availability of handicap parking
- Lack of convenient shopping opportunities
- Transportation
- Hard to get places
- Limited shopping option available in 2 of 4 counties in region E
- Many older adults travel 20 miles or more to shop in nearby counties
- Closing of Winn-Dixie stores will impact the availability of grocery stores in low income neighborhoods in Durham county
- Need more comprehensive assistance paying utility bills

Zoning

- Not much current zoning
- Derelict mobile home parks
- Deteriorated neighborhoods
- Zoning regulations appear to be untouchable in southern rural area and small southern cities
- Educating the public on how proper zoning can improve quality of living conditions and property values
- Anti zoning mindset found in both elected officials and property owners
- Staff in county planning offices need to be educated about older adults and how planning policies can change the physical environment to make it more "senior friendly"

HEALTHY AGING

Adult immunization

- Gaps in service
- Immunization awareness
- Lack of immunization for older adults
- Availability of vaccines

Dental health

- Medicare/Medicaid dental insurance
- Lack of dentists accepting Medicaid for routine dental care
- Lack of resources to pay for routine or emergency dental care in low income seniors
- Increased health care costs
- Lack of dental care compounding health problems
- Lack of availability of dental health care to residents of long term health care facilities, the homebound, and older adults living in rural areas
- Flexible dental care
- Access to affordable dental care programs
- Lack of availability of dental services

Hospitals

- Dementia care in hospitals
- Lack of affordable hospital care
- No hospitals in the area
- Lack of physicians trained in older adult issues
- Transportation to hospitals

Leisure

- Need Senior Center

Nutrition

- Seniors not eating properly (due to frailty, disease process, lifelong poor eating, dental problems etc.)
- Minimal financial resources
- No nearby access to grocery stores
- Lack of transportation
- More wide reaching geographically available home delivered meals
- Meal Sites not fully utilized for MOW
- Additional funding to expand the existing nutrition program
- Provide delivery routes in underserved areas
- Home maker services lacking in every county

Mental health

- Preventive care
- Funding needs
- Curtailment of existing services
- Gaps in services for the developmentally disabled seniors
- Gaps in services for the Low Income Seniors
- Insufficient staff/providers who are "senior focused"
- Inadequate access to mental health services
- State deinstitutionalization of mental health patients requiring a range of appropriate services for the significant number of older adults with mental health problems returning to counties
- Services ensuring the safety of mentally ill older adults back in counties
- Services for mentally ill older adults residing in adult care homes and private residences
- Reform resulted in vacuum of service delivery to older adults who need crisis intervention, case management, and/or counseling
- Lack of service for the indigent mentally ill seniors

Medicare/Medicaid acceptance

- Access to medical facilities
- Lack of health care professionals accepting Medicare clients
- Lack of access to care
- Need more comprehensive coverage under Medicare
- Difficulty in understanding Medicare changes (need simplified benefits)
- Difficulty in understanding Medicaid eligibility (needs simplified benefits)
- Access to SHIIP counselors
- Medicaid and access to dental services

Medications

- Lack of communication between multiple physicians and pharmacists re medication & low cost medication leading to duplicative services, therapies, unnecessary drugs
- Expensive medicines resulting in seniors electing to go without medication
- Training for seniors on drug interactions
- Encouraging pharmacies to develop medication management initiatives for seniors
- Expansion of medication management services to areas targeting rural, minority, and economically needy older adults will prevent likelihood of adverse drug interactions
- Information and assistance on medication management
- Limited assistance available to assist with obtaining medications
- Coordinate medication for the elderly

Preventive care

- Seniors may not routinely seek preventive care due to cost not being covered by Medicare

- Lack of Medigap policy or other health insurance policy
- Lack of preventive care leading to deterioration of health status
- Preventive health care management
- Preventive health education
- Improve air quality
- Initiatives that encourage healthy lifestyles for seniors
- Need to address obesity

Primary care

- Health care costs
- No Geriatricians practice in underserved areas
- Transportation to primary care practices
- Primary care wait lists for in-home aide service, staff retention, heavy turnover in key service providers
- Monopoly of services in certain areas

Rehabilitation

- Cost

Vision/hearing care

- Lack of affordability
- Cost of hearing aids

Wellness/fitness

- Senior center
- Increased physical activity for seniors
- Promote and enhance fitness trails
- Lack of wellness and fitness initiatives for seniors

ECONOMIC SECURITY

Job training

- Job link accessible
- Loss of manufacturing jobs
- Requires new job training techniques
- Promote community college system

Age discrimination

- Professional senior citizens more susceptible to age discrimination
- Advocate for hiring older adults to high pay jobs

Financial planning (no issues submitted)

Health care cost

- National problem
- Real problem for low income seniors
- By 2020, Western North Carolina population 65+ will be 1 in 4—huge impact on socio-economic system
- Healthcare costs too high
- Affordable healthcare even with Medicare coverage is difficult for many low income seniors in the region
- Lack of primary care or physician specialties creates higher emergency department costs and inpatient stays, thus contributing to the healthcare costs across the board
- Healthcare costs, including prescription drugs, leave few dollars for other needs for the low income elderly

Health insurance

- Cost is a problem
- Low income elderly slip through the cracks and are highly vulnerable
- High health insurance costs
- Medicare inadequate in covering costs especially for the lower income, non-Medicaid eligible seniors who cannot afford co-pay
- Older adults under 65 finding retiree health insurance coverage from former employers increasing in cost and unaffordable
- Employers not offering health insurance for retirees
- Employers limiting access to affordable health care for retirees
- Free clinics experiencing an increase in the number of older adults seeking medical care
- High number of uninsured clients
- Medicare needs to offer more comprehensive coverage, and general healthcare needs to be more affordable
- Need affordable, flexible dental care
- Health care costs (including medications) and the cost of health insurance (supplements) continue to be a priority issue

Income

- With plant closings, seniors are in trouble
- Sustainable income necessary for economic gain
- Focus more on tourism
- Need high income older adults
- Approximately 23 percent of 60+ population in Region R have incomes between 100-199 percent poverty level
- Inadequate programs and funding to address the service needs of low-income families not eligible for Medicaid and not able to afford private-pay services
- Economic impact in region from layoffs in textile, tobacco manufacturing, tobacco farming led to drop in financial support for all services including services for older adults

- Young old workers who have been displaced, have no retirement plans, lack health care, and are beginning to experience economic hardship as unemployment is exhausted
- Region E has the largest number of seniors living off of fixed income sources such as Social Security
- Region E has the lowest level of educational attainment
- The low-income seniors do not have sufficient income for basic needs

Job opportunities

- Labor intensive low skills jobs are not coming back
- Service industry—low wages, largest complaint
- Encourage temps to hire older adults
- Focus on future impact of senior population on workforce development due to fewer persons who wish to be employed, less industry in the counties, and movement to a more "service-oriented" income from this population
- High unemployment of older adults
- Less job opportunities available to seniors due to plant closings and layoffs

Job retooling

- Workers over 55 most vulnerable. AB Tech big asset
- Need retirement planning
- Transition classes
- Training and employment opportunities for older workers are increasingly scarce
- Partnerships with local ESC offices, Job Link Centers, and local employers critical for Title V program

Senior-friendly businesses

- Utility costs high
- Utility funding needed for the rising heating costs and low limits available from service providers
- Some seniors do not know how to access services/resources, or they need assistance to do so

Long-term care costs

- Serious problem
- Western North Carolina is not prepared for influx of senior population in nursing homes in 5 to 10 years
- Prohibitive costs
- Provide low cost option for older adults
- Some facilities can't afford more
- Prohibitive long term care costs
- Continuing rise in the cost of adult care and nursing homes especially for the private pay older adult
- Facilities are beginning to charge persons for incontinence care. "Levels of care" being defined by individual facility
- Funds getting exhausted quickly and often creating a need to move from a private pay facility to one that accepts Medicaid or Special Assistance
- The workforce will need more older workers, older workers will need to continue working for economic security and access to health care resources, and baby boomers need to be educated about planning for funding long-term care and long-term care insurance as one of those resources

Tax credits/exemptions

- Family oriented

TECHNOLOGY

Internet access

- Provide low cost options for older adults
- Internet access for older adults with limited resources
- Computer literacy and internet access for older adults in rural areas
- Consumer education and training to make technologies available to seniors
- Need more sites to access internet

Assistive/adaptive devices

- High priority
- Limited resources in obtaining adaptive devices
- Lack of information on the various types of devices and how to secure them
- Older adults do not have easy access to agencies that provide information and assistance on adaptive devices
- Lack of funding to assist with cost of devices not covered by Medicare or other insurance
- Inadequate programs and funding for assistive/adaptive devices

Distance learning

- Very difficult to provide training and equipment to rural poor
- No tech or model available in counties for aging consumers to access long-term and supportive services

- Need for basic computer training for displaced older adults

Medical alert

- Provide no cost to high risk older adults
- Medical alert services available but cost prohibitive for many 60+ residents

Tele-medicine *(no issues submitted)*

Telephone/cell phone access

- Can't get 211 financed
- Provide low cost access
- Provide discounts to older adults
- Some areas not equipped
- Problems of access for rural poor
- Many parts of region E lack broadband access
- Quality internet access is not available in all counties
- Cell phone use limited in Surry and Stokes counties because of mountain ranges
- Lack of cell phone coverage area
- Limited cell phone reception capabilities

SAFETY AND SECURITY

Driver safety

- Driver safety classes for elderly drivers
- Provide driver training for elderly
- Driver safety high priority issue
- Driving safe issues
- Few programs to enhance an older driver's skills
- No insurance reduction incentives
- Roadways not designed for older drivers and do not include wider white lines or longer wait at traffic signals
- Families and professionals are reluctant to suggest to older persons that evaluation of driver safety might be necessary
- Few alternative transportation options for non-drivers
- Lack of affordable counseling services for those with functional limitations who must become dependent on others for transportation as a result of non-renewal of driver's license

Abuse/neglect

- Ongoing abuse and neglect in nursing homes
- Residents fear eviction from a facility and often remain silent
- Expand senior companion idea
- Reactivate elder abuse task force
- Helpmate elder abuse training
- Ongoing problem
- Problem with rural poor
- Increase in incidence of abuse and neglect in long-term care facilities
- More older people living alone without necessary supports creates incidences of self neglect
- Individuals do not know where to seek help
- Older adults may not realize they need services/supports
- Continued education on what constitutes elder abuse/neglect
- Increasing number of people with powers of attorney without any safeguards or accountability
- Strengthen the APS law to prosecute perpetrators of abuse

At-risk population

- Consumer education conference
- Unable to care for themselves
- Living in remote areas
- Higher rates of life expectancy creates a segment of older people who deteriorate over time and do not have the proper supports in place to live safely at home
- Frail individuals rotate in and out of hospitals due to medical crisis and are at further risk because of shortened hospital stays, lack of family and/or agency support, and inability to afford in-home care
- Older adults at risk of wandering need to have security measures in place
- Medic alert (Lifeline) service needs to be more affordable
- Many seniors need deadbolts, better locks, peepholes on their doors and windows. Some need security systems, smoke detectors, carbon monoxide detectors, etc.
- Expand services to and publicize existing programs in Rowan Co. like "Are you OK?" and the SAFE program

Domestic violence

- Few programs designed to address elder domestic violence
- Shelter staff may not be sensitive to issues of aging and their specific problems
- Lack of designated "senior area" in domestic violence shelters
- More education of elder domestic violence for law enforcement staff in handling victims
- More information to senior population is needed

Emergency response

- Special needs databases such as in Henderson Co. are a model practice
- EMS provided by Buncombe county and could be problematic in the event of a disaster

- Good emergency response but means of getting it (cell phone, pager) are expensive
- Region P very vulnerable to hurricanes and other severe weather. Emergency response needs to focus on those issues
- Disaster preparedness with focus on aging issues a high priority
- Unique rural challenges for EMS
- Distances from medical communities
- Rurality of communities
- Isolation of two island communities
- Inadequate utilization of special needs registries for emergency preparedness
- Provisions for continuation of nutrition services during a disaster or emergency for homebound seniors

Fire safety

- Some elderly more susceptible to fire due to dementia
- Offer inspections and assistance through volunteer fire department
- Resources and finances are a big issue
- Education needed

Fraud/exploitation

- Increase information
- Vulnerability of seniors to frauds and scams
- Planning for homeland security initiatives
- Rural area scams due to lack of knowledge and education
- Continued community education on all kinds of fraud
- Enhance education to seniors, law enforcement officers and other professionals on preventive measures
- Financial exploitation by family members, trusted friends and /or workers
- Older adults reluctant to prosecute due to embarrassing nature of incident
- Diversion of older peoples' assets to family members becoming increasingly common
- Depletion of funds, deterioration due to lack of care, inadequate medications and/or food
- Need to address the exploitation of senior adults in their homes, who give power of attorney and "large financial gifts" to people who befriend them, and then exploit them
- Seniors are inundated with mail offers that offer them products, which aren't that useful at exorbitant prices
- Telemarketers get vital and private information over the phone from senior adults and sell them things that they don't really need
- Senior adults who become frail or are suffering from several chronic conditions are often targets for predators
- Often a person will befriend an older adult and then exploit them financially
- Bogus repairmen often will make a contract to do house repairs and overcharge or walk away with the money and never finish the job.
- Fraud/exploitation of senior adults has risen

Outreach

- Seniors need to be better informed
- Lack of initiatives on aging that would allow seniors to remain in their own homes
- Outreach and education efforts need to protect older adults from financial exploitation in rural communities
- Multifaceted outreach efforts on many topics
- Safety and security high priority for outreach efforts
- Lack of law enforcement presence for patrolling in high crime or isolated areas

SOCIAL AND CULTURAL OPPORTUNITY

Volunteerism

- Promote services
- More volunteers needed
- Promotion of volunteers
- Change in the type of volunteer and time commitment
- Volunteers devoting less time to a cause
- Overall decrease in volunteers for programs such as home delivered meals in both urban and rural counties
- Increase access and funding for social/ cultural resources/opportunities and increase community education regarding existing resources
- Increase community volunteerism to offset budget restraints
- There is a huge need for more home delivered meals volunteers
- The agencies need to develop and train a group (or groups) of volunteers to visit every senior in the county and leave a packet of information and conduct a survey of the status of that senior

Community sensitivity

- Community in general is not always "aging friendly"
- More programs needed to dispel the myth of aging

- Create a climate of acceptance by all age groups
- Educate faith community about available services

Media (no issues submitted)

Intergenerational relations

- Expand use of current services
- Lack of media coverage with respect to local news impacting senior

Libraries (no issues submitted)

Lifelong learning

- "Building Bridges" understanding cultures
- Promote lifelong senior courses at community college
- Need scholarships for low income
- Need a senior center to address the need
- Access is very limited for low income seniors
- Transportation issues
- Inability to pay any fees associated with classes

Spiritual growth (no issues submitted)

Racial/ethnic/linguistic diversity

- Need to reach minorities
- Many minority older adults now
- Preservation and understanding of the cultural uniqueness of all racial and ethnic groups is critical to delivering effective services
- Non English speaking clients necessitate the expense of providing interpreter services
- Reach out to non-English speaking senior adults

Cultural/social programs (no issues submitted)

The Arts (no issues submitted)

ACCESS AND CHOICE IN SERVICES AND SUPPORTS

Information and assistance (I&A)

- Promote available resources
- 211 is a tremendous distribution of information
- Does it reach rural areas
- Need coordinated system for creating awareness and accessing information on services for the aging population
- Need a single portal of entry
- Lack of coordinated referral system in Durham county
- HCCBG program utilization is an issue
- Innovative methods needed to disseminate information about services, particularly to older adults in rural areas with limited literacy
- Single access point not available to persons seeking information/services
- System is fragmented, not easily accessible, and lacks coordination among service agencies
- Information and Assistance is always an area that needs to be expanded and refined. Therein lies the ability to access knowledge regarding life-sustaining and quality of life issues for all age individuals
- Aging services need to collaborate to put together a standardized and attractive packet of information that could be distributed to seniors through real estate agents, or churches who are welcoming visitors or receiving new members who are senior adults

Caregiver support

- Expand and promote needs of caregivers
- Need to make businesses more attuned to the needs of their caregiving employees
- Lacking adequate programs that provide respite to a caregiver routinely
- Caregivers do not have time to access services to seek information, assistance, and training
- Inadequate funding to assess caregiver needs
- Inadequate funding to support supplemental staff
- All counties report and document waiting lists for respite care
- There is a lack of sufficient services for seniors and their caregivers to enable the caregiver to continue to provide care. At a minimum such services include respite, home modification and equipment, housing repairs, and caregiving supplies

Drug assistance

- Financial assistance needed
- Need to review what's available and promote
- Access to affordable medications
- Prescription assistance
- Continuation of funding for prescription assistance programs
- Large number of seniors need drug assistance to secure low cost/no cost medication
- Seniors do not know who to call for drug assistance
- Seniors do not take prescription drugs in order to purchase food
- Contributes to exploding health care costs due to drug interactions, duplicative therapies
- Prescription drugs need to be more affordable

End-of-life care

- Need a building/caregiver hospice
- Need to educate people
- Expansion of local and regional coalitions to work on end of life care issues

Grandparents raising grandchildren

- Becoming a growing issue
- Large number of grandparents raising their grandchildren
- Additional services and support needed for grandparents serving as parents
- There are grandparents, who are raising their own grandchildren and don't know about services and programs available to help them

Legal services

- Have lots of attorneys
- Long waiting list for Legal Aid of NC
- Most service requests for health care directives, power of attorney, general and living wills
- Need accessible and affordable legal services
- Needs to be more low-cost, quality legal services available to seniors
- They need help to prepare wills, living wills, durable power of attorney, estate planning, etc.

Senior centers

- Create a literacy program for senior adults
- Centers must respond to changing demographics
- Offer a wide variety of programs to meet the needs of boomers
- Technology savvy programs and services
- Prepare for a different flow of information
- Lack of staff availability to support senior centers

Home and community services

- Funding is limited
- Waiting lists for in-home aide services
- Need for adult day care centers
- Need for adult day care programs is high
- Waiting list for in home aide services
- Waiting list for home delivered meals
- Inadequate public funding even with an ever increasing senior population
- Lengthy waiting lists contribute to deterioration in condition, hospitalization, and long term care placement
- Inadequate funding to meet core service needs in the region
- There are no Adult Day Care or Adult Day Health programs available in Anson County
- Adults with chronic conditions or beginning stages of Alzheimer's must stay at home
- Need increased funding for services
- Need more funding to expand Adult Day Care services
- Increase funding for services to meet growing needs
- There is a need for home-delivered services. The goal is to help senior adults stay in their homes because of more services like CAP/DA and consumer directed care
- There are a wide variety of services available in the county seat, but very few in the rural areas
- Need affordable adult day care
- Increased funding for services—access to services is limited due to waiting list for nutrition and in-home aide services
- Many senior adults fall through the cracks and don't meet eligibility for help when they need it
- Other seniors cannot get help because Service Providers have limited funding and waiting lists for services
- There is a huge need for in-home services both Level I and II since none are now available through the block grant
- Waiting lists for home delivered meals
- Home delivered meals are needed for the more rural areas
- There is a need to have a geriatrician work with the Health Department

Long-term care facilities

- Need to increase minimum staffing requirements in facilities
- Inadequate number of beds to meet current and/or future needs
- Inadequate staff who are paid competitive salary/benefits
- Resident/family issues require more extensive training for all staff
- Lack of mental health services to assist facility staff to respond to needs of residents escalating costs of LTC and less public benefits to assist low income seniors and others
- Lack of staff availability to support long term care facilities

Guardianship

- Guardianship is a key issue being pursued by elected state officials in Orange county

Care management

- Case management is needed and not available

PUBLIC ACCOUNTABILITY AND RESPONSIVENESS

Public benefits

- Public knowledge of aging programs and services is essential
- Lack of funding and single access point to seek information on benefits and/or apply

Community needs assessments

- Needs assessment to facilitate planning for senior friendly communities
- Community assessment coupled with the development of an Area Agency on Aging strategic plan
- Assessment of needs is essential
- Inadequate focus on the impact of large number of retirees into the area
- Lack of attention to the infrastructure development in communities to meet needs of larger senior population
- Assessment of services/resource availability

Planning and coordination

- Employers must prepare for boomer retirement
- Boomer impact
- Coordinated long range plan for future of aging services
- Lack of advanced planning for financial, health, and long-term care needs
- Development of a senior center in many counties
- Establishment of a taskforce to examine successful programs in rural counties
- Involve diverse segments of community to plan for aging programs
- Multiple planning teams creating duplication of effort
- Lack of integrated single point access planning
- Streamline planning process by collapsing planning groups into one effort
- Number of retirees migrating to the area highlights the need to disseminate relocation information specific to older adults to facilitate planning for current or future needs
- Many seniors don't know where to look for help. They also aren't knowledgeable about services and programs that exist

Program evaluation

- Drop programs that are not effective

Public and private funding sources

- Pursue avenues to leverage funding sources
- Any new program or service that costs is difficult to initiate
- Aging service providers and residents would like the help of a nonprofit grant writer
- The community must find ways to increase public and private funding sources for services
- Utilize increased community collaboration to maximize community resources
- There is limited public funding available and limited private funding as well

Taxes

- More focus on planning for decreased tax base due to fewer people in the workforce as well as decreased pool of workers

Representation in public affairs

- Expand/ promote
- Seek support for aging programs from state and local elected officials
- The community needs to expand Information and Assistance resources

Appendix D: Views of Advocates

PRIORITIES FOR FISCAL YEAR 2007–08

North Carolina has a number of groups and organizations whose members actively study and represent the views of older adults in helping shape public policy. As was done with the *2003–2007 Plan*, the views of four bodies are presented below. Three—the Governor's Advisory Council on Aging (GAC), the North Carolina Senior Tar Heel Legislature (STHL), and the North Carolina Study Commission on Aging (Commission)—have authority under State law to offer recommendations for improving the well-being of seniors. The fourth group—the North Carolina Coalition on Aging (Coalition)—was included because it represents the views of many different organizations who collaborate to develop a legislative agenda.

The STHL was created by the General Assembly in 1993 with the passage of S.B. 479. With one delegate, and often an alternate, 60 years of age or older from each of North Carolina's 100 counties, the STHL assesses the needs of older citizens and establishes annually up to five priorities for consideration by the General Assembly. They chose five priorities for SFY 2007–08. Created in 1973, the GAC is charged by NCGS 143B-180 to recommend to the Governor and the DHHS Secretary ways to improve services to older adults. For SFY 2007–08, the GAC has seven recommendations.

In turn, NCGS 120-21 charges the Commission to study and evaluate the existing system of delivery of State services to older adults and to recommend an improved delivery system to meet their current and future needs. With a membership of 17, the Commission met nine times and held public hearings in Charlotte and Burlington to develop its report to the Governor and the 2007 Regular Session of the General Assembly. This report contains 17 recommendations.

The Coalition is a statewide alliance of consumer, trade, governmental, educational, and professional organizations committed to improving the quality of life for older adults through legislative, other governmental, and community action. Included among the 40 member organizations supporting the Coalition's recommendations are AARP NC, the Association of NC Boards of Health, Friends of Residents in Long Term Care, the Mental Health Association in North Carolina, the NC Association of County Directors of Social Services, the NC Association of Long Term Care Facilities, the NC Association on Aging, the NC Disabled American Veterans, the NC Health Care Facilities Association, and the NC League of Women Voters.

The first 11 items listed in the table of priorities are those for which a fiscal note has been identified. The only two items set as priorities among all four groups are (1) an increase in funding for the Home and Community Care Block Grant, and (2) an increase in funding for Senior Centers. For many of the items, an additional explanation is provided in the endnotes.

Item	Governor's Advisory Council on Aging	Senior Tar Heel Legislature	Coalition on Aging	Study Commission on Aging
1. Increase Home and Community Care Block Grant, by:	$10 million	$5 million	$5 million	$5 million
2. Increase Support for Senior Centers, by:	$2 million[1]	$634,684	$2 million[2]	$500,000
3. Expand Dental Care for Special Care Populations		$1.35 million[3]		$200,000[4]
4. Assist with Indoor Plumbing	$2 million[5]			
5. Relieve Counties of Medicaid Cost		$450 million[6]		
6. Expand Health Care Personnel Registry				$1.7 million[7]
7. Support Project C.A.R.E. (Caregiver Alternatives to Running on Empty)				$500,000[8]
8. Support Adult Protective Services Pilot Program				$1,492,000[9]
9. Increase Availability of Housing Options for Persons with Mental Illness through Rental Assistance				$1,506,600[10]
10. Authorize Star-Rated Certification for Adult Care Homes				$153,000[11]
11. Fund the WIN A STEP UP Program for Nurse Aides				$400,000[12]
12. Increase Medicaid Asset Limit	X		X[13]	
13. Provide Additional Prescription Drug Assistance		X[14]		–[15]
14. Ensure Viability of the Community Alternatives Program for Disabled Adults (CAP/DA)	X		X[16]	
15. Increase Slots for State/County Special Assistance In-Home Program			X	X[17]
16. Reinstate LTC Insurance Tax Credit	X			
17. Enact "De factor Custodian Law"	X[18]			
18. Wage Pass-through for Aides			X[19]	
19. Remove Institutional Biases			X	
20. Study Medically Needy Income Standard				X
21. Study Housing Concerns and Staff Training Required for Mixed Populations				X
22. Support Transitional Residential Treatment Program and LME Notification of Mental Health Determination Using Uniform Screening Tool				X
23. Amend Penalty Review Committee Statutes				X
24. Study Safe Transportation of Wheelchair Passengers				X
25. Support Recommendations from the House Study Committee on State Guardianship Laws				X

[1] Identified $200,000 to be kept at DAAS for related training, planning, and administration.

[2] Identified $300,000 to be kept at DAAS for related training, planning, and administration.

[3] For use by the Office of Rural Health in recruiting dentists for underserved areas and for support of mobile dental clinics.

[4] For use by the Division of Public Health to purchase an additional mobile dental unit.

[5] Governor's Advisory Council notes that 8,184 older households did not have complete plumbing as of 2000 Census.

[6] In addition, the Senior Tar Heel Legislature states that the State's assumption of Medicaid responsibility should not alter the current tax allocation to counties while maintaining current State levels of services.

[7] To include unlicensed staff and to improve allegation response times.

[8] Project C.A.R.E. is a demonstration program that supports family caregivers of persons with dementia.

[9] Supports an initiative of the Division of Aging and Adult Services to reform Adult Protective Services; would increase amount to $1,930,000 for FY 2008–09.

[10] Would increase amount to $3,013,200 for FY 2008–09.

[11] Would decrease amount to $108,000 for FY 2008–09 following some start–up costs.

[12] $200,000 for developing and piloting program for in–home aides in FY 2007–08 and 2008–09; $200,000 in FY 2007–08 and $325,000 in FY 2008–09 for continuing program in nursing homes.

[13] Both the Governor's Advisory Council and the Coalition on Aging advocate increasing the asset limits for categorically and medically needy Medicaid eligibility for aged, blind, and disabled persons from $2,000 to $6,000 for individuals and from $3,000 to $9,000 for couples.

[14] While not giving a dollar figure, supports those who need help during the "doughnut hole" coverage period of Medicare Part D.

[15] Supports the NCRx program.

[16] Supports an increase in CAP/DA slots.

[17] The Study Commission identified a figure of 2,000 slots.

[18] Would allow a court to grant a caregiver the legal authority necessary to adequately parent the children in their care.

[19] Supports increased funds to adult care homes, nursing homes, and home care services to increase salaries and benefits for aides.

Appendix E: Expenditures by Funding Source, Service, and Service Category for People 60 Years and Older in SFY 2005–06

	Category	Clients	Expenditure
Funding Source: Department of Transportation			
Elderly and Disabled Transportation Assistance Program	6		$5,675,254
		TOTAL	$5,675,254
Funding Source: Division of Aging and Adult Services			
Adult Day Care	4	549	$1,654,681
Adult Day Health	4	559	$1,634,894
Care Management	6	224	$893,443
Congregate Nutrition	6	26,778	$10,919,120
Consumer Directed Care	4		$43,204
Family Caregiver Support - Access	6	1,603	$515,865
Family Caregiver Support - Counseling/Support Groups/Training	6	1,140	$411,135
Family Caregiver Support - Information	6	13,487	$964,981
Family Caregiver Support - Respite Care	6	1,596	$1,504,701
Family Caregiver Support - Supplemental Services	6	786	$308,170
Group Respite	6	72	$90,547
Health Promotion/Disease Prevention	3		$459,873
Health Screening	3		$20,683
Home Delivered Meals	4	16,977	$10,977,945
Home Health	4	29	$24,295
Housing and Home Improvement	6	1,323	$835,160
In Home Aide Level 1	4	3,596	$5,062,104
In Home Aide Level 2	4	3,766	$9,614,370
In Home Aide Level 3	4	1,032	$2,844,178
In Home Aide Level 4	4	17	$32,794
Information & Assistance	6		$1,573,296
Institutional Respite	6	64	$224,661
Legal	6		$419,301
Medication Management	3		$245,340
Senior Center	6		$4,684,421
Senior Companion	4	80	$135,035
Transportation, General	6	10,193	$5,546,297
Transportation, Medical	3	3,382	$913,748
Volunteer Program Development	6		$158,421
	TOTAL		$62,712,663

	Category	***Clients***	***Expenditure***
Funding Source: Division of Medical Assistance			
ACH-PCS Basic/Enhanced	1	18,147	$94,444,971
ACH-Transportation	1	17,967	$2,768,876
CAP/AIDS	4	8	$161,957
CAP/CHOICE	4	12	$127,527
CAP/DA	4	11,438	$203,663,839
CAP/MR	4	289	$11,454,036
Clinics	3	36,244	$28,102,805
Dental	3	42,935	$14,509,420
HMO	2	11,553	$8,562,035
Home Health	4	82,094	$55,892,577
Hospice	4	4,079	$40,346,516
ICF-MRC	5	439	$48,751,201
Inpatient Hospital	5	24,729	$83,011,284
Inpatient Mental Hospital	5	199	$6,367,154
LAB & XRAY/Physicians	3	174,235	$93,574,015
Medicare Part A & B Premiums	2	194,766	$225,060,869
Medicare Part D Clawback	2	145,187	$59,595,722
Nursing Homes	5	38,693	$982,374,207
Other Care	3	73,947	$14,205,482
Other Practitioners	3	69,336	$6,319,064
Outpatient Hospital	3	92,968	$54,608,050
Prescribed Drugs	3	162,702	$383,385,926
Regular Personal Care (PCS)	4	31,572	$189,723,391
		TOTAL	$2,607,010,924

Funding Source: Division of Mental Health/Developmental Disabilities/Substance Abuse			
Alcohol Rehabilitation Centers	5	30	$159,693
Developmental Disabilities	3	884	$4,974,866
Mental Health	3	17,576	$3,402,674
Mental Retardation Centers	5	325	$51,013,937
Psychiatric Hospitals	5	1,179	$62,133,077
Substance Abuse	3	2,011	$772,183
		TOTAL	$122,456,430

	Category	*Clients*	*Expenditure*
Funding Source: Division of Services for the Blind			
Adjustment Services for the Blind and Visually Impaired	6		$247,651
Independent Living Rehabilitation Program	3	604	$337,391
In-Home Services Level 1 Home Management	4		$356,279
Medical Eye Care Program	3	331	$356,456
Rehabilitation	3	356	$598,535
Special Assistance for the Blind	1	41	$231,528
		TOTAL	$2,127,840
Funding Source: Division of Social Services			
Adult Care Home Case Mgt./Screening	1	4,757	$2,739,962
Adult Day Care	4	671	$2,110,963
Adult Day Health	4	326	$1,362,459
Adult Placement	6	513	$149,139
Adult Protective Services	6	5,454	$3,146,785
At-Risk Case Management	6	2,025	$1,177,017
Energy Assistance	2	60,033	$2,962,948
Food Stamps	2	92,078	$63,572,835
Guardianship Services	6	1,787	$1,766,540
Housing & Home Improvement	6	155	$339
In-Home Aide Services	4	5,761	$5,475,922
Meals - Home and Congregate	4	1,000	$102,298
Other Services	6	10,325	$12,774,328
Special Assistance: Adult Care Home	1	18,056	$70,999,119
Special Assistance: In Home	4	697	$1,869,717
Transportation	6	5,294	$982,058
		TOTAL	$171,192,430
Funding Source: Division of Vocational Rehabilitation			
Independent Living	3	1,672	$3,707,636
Vocational Rehabilitation	6	629	$1,306,692
		TOTAL	$5,014,328

Schedule of Reported Expenditures by Funding Source and Major Service Category
SFY 2006–06

Funding Source	1. Adult Care Homes	2. Economic Support	3. Physicians, & Other Health Care	4. Home Health & In-Home Care	5. Institutional Care	6. Social Supportive Services	Totals	Percent
Department of Transportation						$5,675,254	**$5,675,254**	**0.19%**
Division of Aging and Adult Services			$1,639,644	$32,023,500		$29,049,519	**$62,712,663**	**2.11%**
Division of Medical Assistance	$97,213,847	$293,218,626	$594,704,762	$501,369,843	$1,120,503,846		**$2,607,010,924**	**87.60%**
Division of Mental Health/ Developmental Disabilities/ Substance Abuse Services			$9,149,723		$113,306,707		**$122,456,430**	**4.11%**
Division of Services for the Blind	$231,528		$1,292,382	$356,279		$247,651	**$2,127,840**	**0.07%**
Division of Social Services	$73,739,081	$66,535,783		$10,921,359		$19,996,207	**$171,192,430**	**5.75%**
Division of Vocational Rehabilitation			$3,707,636			$1,306,692	**$5,014,328**	**0.17%**
Totals	**$171,184,456**	**$359,754,409**	**$610,494,147**	**$544,670,981**	**$1,233,810,553**	**$56,275,323**	**$2,976,189,869**	**100.00%**
Percent	**5.75%**	**12.09%**	**20.51%**	**18.30%**	**41.46%**	**1.89%**	**100.00%**	

Appendix F: Acronyms

NORTH CAROLINA STATE GOVERNMENT OFFICES AND AGENCIES

DAAS	Division of Aging and Adult Services
DCR	Department of Cultural Resources
DFS	Division of Facility Services
DHHS	Department of Health and Human Services
DIRM	Division of Information Resource Management
DMA	Division of Medical Assistance
DMH/DD/SAS	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
DOJ	Department of Justice
DPH/CDI	Division of Public Health/Chronic Disease and Injury Section
DPH/HDSP	Division of Public Health/Heart Disease and Stroke Prevention
DSB	Division of Services for the Blind
DSDHH	Division of Services for the Deaf and Hard of Hearing
DSS	Division of Social Services
DVR	Division of Vocational Rehabilitation
ESC	Employment Security Commission
HFA	Housing Finance Agency
LTS Cabinet	Long Term Services and Supports Cabinet
NCDOI	Department of Insurance
NCDOT	Department of Transportation
OEO	Office of Economic Opportunity
OCS	Office of Citizen Services
OLTS	Office of Long Term Services and Supports
OMHHD	Office of Minority Health and Health Disparities
ORHCC	Office of Rural Health and Community Care

NORTH CAROLINA REGIONAL OR COUNTY GOVERNMENT

AAA	Area Agency on Aging
APS	Adult Protective Services, through county departments of social services
DSS	County Department of Social Services
LME	Local Management Entity, the regional organization that manages the delivery of public mental health services
NC4A	North Carolina Association of Area Agencies on Aging

FEDERAL GOVERNMENT

AoA	Administration on Aging
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
DHHS	US Department of Health and Human Services
HUD	Department of Housing and Urban Development
IRS	Internal Revenue Service
USDA	US Department of Agriculture

OTHER ORGANIZATIONS AND PARTNERSHIPS

AARP NC	Formerly the American Association of Retired Persons; AARP NC, the North Carolina chapter of this organization
AAA Carolinas	Automobile Association of America, North and South Carolina
CCME	Carolinas Center for Medical Excellence
EDS	Electronic Data Systems Corporation
DDTI	UNC's Developmental Disabilities Training Institute
IoA	UNC Institute on Aging, serving the 16 campuses of the University of North Carolina, located in Chapel Hill
MPSLCC	Medicare Partners State Level Coordinating Committee. Members of this committee include departments and divisions of State and federal government: NC AIDS Drug Assistance Program; NC4A; NC Coalition on Aging; NC Cooperative Extension Service; DHHS Office of Citizen Services; DAAS; DMA; DMH/DD/SAS; NC Office of Minority Health and Health Disparities; Office of Rural Health and Community Care; NCRx; State Health Plan; Social Security Administration) and private or nonprofit organizations (AARP NC; General Baptist State Convention; Health and Disability Advocates; Health Inequities Program; Kerr Drugs; Medicare RX Assist Network; Medicare Today Program; Mental Health Association in North Carolina, Inc.; My Medicare Matters Program; NC Association of Pharmacists; NC Retired Governmental Employees Association; NC Retired School Personnel; Senior PHARMAssist).
NCHAC	Healthy Aging Coalition. Members of this coalition include AARP NC; NC Division of Public Health; Carol Woods Retirement Community; NC Hospital Association; Carolina Geriatric Education Center; NC Institute for Public Health; Centralina Area Agency on Aging; NC Prevention Partners; East Carolina University; NC Senior Citizens Association; General Baptist State Convention; NC Senior Games; Mountain Area Health Education Center; NC Teachers and State Employees Comprehensive Major Medical Plan; NC Area Health Education Center; Office of Healthy Carolinians; NCAAHPERD; Office of Minority Health and Health Disparities; NC Cooperative Extension; Pitt County Community Schools and Recreation; DAAS; SAS Institute; MH/DD/SAS; State Center for Health Statistics; DMA; UNC Institute on Aging.
NCSG	North Carolina Senior Games
NCSDSC	NC Senior Driver Safety Coalition
NCSU	North Carolina State University
WDS	Workforce Development System
UNC	University of North Carolina
UNC CARES	Center for Aging Research and Educational Services at UNC-Chapel Hill School of Social Work

GRANTS, PROJECTS, AND PROGRAMS

ADRC	Aging and Disability Resource Centers /or Connections
AFED	Arthritis Foundation Exercise Program
CAP-DA	Community Alternatives Program for Disabled Adults
CAP-Choice	Community Alternatives Program for Disabled Adults, consumer-directed option (pilot)
Project C.A.R.E.	Caregiver Alternatives to Running on Empty
CDSMP	Chronic Disease Self Management Program Grant
EBT Cards	Electronic Benefit Transfer Cards
HCCBG	Home and Community Care Block Grant
ILR	Division of Services for the Blind's Independent Living Rehabilitation
NCATP	NC Assistive Technology Program within DVR
NCEOLCC	NC End of Life Care Coalition
NC NOVA	NC New Organizational Vision Award
NC POMP	North Carolina Performance Outcomes Measurement Project (part of a federally- funded project)
NCRx	Prescription drug assistance plan to help seniors with low incomes participate in the federal Medicare Part D prescription drug program
PACE	Programs of All-Inclusive Care for the Elderly
PCS	Personal Care Services
SA/IH	Special Assistance In-Home Project
S.A.F.E.	Strategic Alliances for Elders in Long-Term Care
SHIIP	Seniors' Health Insurance Information Program (under the Department of Insurance)
Senior PHARMAssist	Senior PHARMAssist (in Durham) promotes healthier living for seniors by helping them obtain and better manage needed medications and by providing health education, community referral, and advocacy
SSBG	Social Services Block Grant
SSI	Supplemental Security Income

OTHER ABBREVIATIONS

ARMS	Aging Resources Management System
I&A	Information and assistance about services for older adults and those with disabilities; differs from information and referral (I&R) by amount of help and follow-up provided
I&R	Information and referral (see I&A)
IT	Information technology
MOA	Memorandum of Agreement
NC care LINK	A comprehensive web-based information and referral system that includes information about services and supports statewide
OAA	Federal Older Americans Act
QI	Quality Improvement
Web	World Wide Web

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